

CHINESE PEOPLE AND MENTAL HEALTH SERVICES  
IN CHRISTCHURCH: PROVIDER PERSPECTIVES

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## **Abstract**

The Chinese population in New Zealand has grown rapidly in recent years, and it has become an important component in New Zealand society. In reality, these Chinese people are likely to be under stress in their new lives, and therefore, at high risk of mental health problems. Moreover, evidence shows that Chinese people are the under-users of mental health services, and that mental health issues among the Chinese population tend to be under-recognised, under-reported and untreated. Therefore, the method of descriptive qualitative study was chosen and semi-structured interviews were carried out to describe how health providers perceive and support mental health needs of Chinese patients in Christchurch. Purposive sampling was used to identify potential participants, namely the health providers, who have experience of working with Chinese people's mental health issues. They were recruited from a wide range of health services, including general practice, psychiatry, social work, counselling, project leadership, health promotion, different management roles, nutrition, nursing, and Chinese medicine. Data analysis was assisted by the computer software Nvivo 8, with thematic analysis used to identify themes and sub-themes which emerged from the information of the interviews.

From the health providers' point of view, migration-related stressors and physical problems all pose risks to Chinese people's mental health. Although Chinese clients with mental health problems are not commonly seen in the clinical settings, they do potentially have mental health problems and suffer from these issues, but rarely seek mental health support from mainstream services. The health providers pointed out that although good mental health services and information are offered to local people, the existing health care model and health system do not meet Chinese people's mental health needs, due to barriers of language and culture. Under these circumstances, the providers indicated that establishing cultural and linguistic mental health services, and offering education to Chinese people and health providers might be helpful in overcoming cultural barriers, improving low access issues and meeting Chinese people's mental health needs. This study also identified a range of mental health problems and some groups among the Chinese population with a high risk of mental health issues, both of which need further investigation.

## Glossary

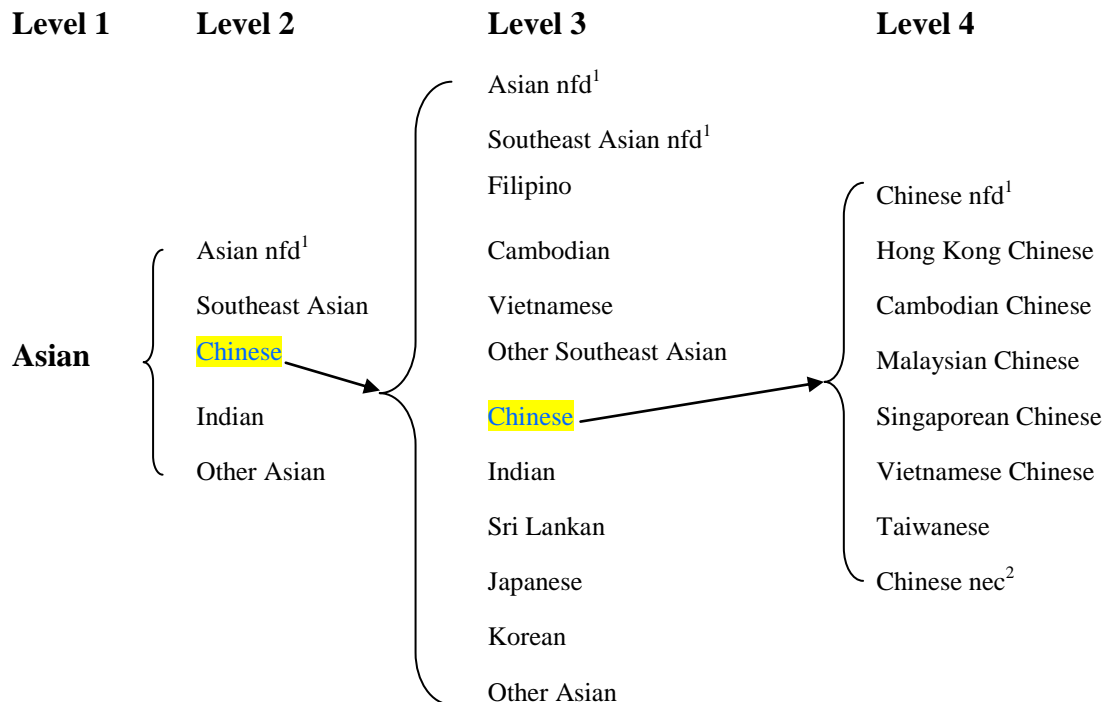
**Mental health** refers to a broad array of activities directly or indirectly related to the mental well-being component included in the World Health Organisation (WHO)'s definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease". It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders (WHO, 2011b).

**Mental disorder/Mental illness** (WHO, 2011a) comprises a broad range of problems, with different symptoms. However, they are generally characterised by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, mental retardation and disorders due to drug abuse. Most of these disorders can be successfully treated.

**Ethnicity/Ethnic group:** Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group. An ethnic group is made up of people who have some or all of the following characteristics: a common proper name; one or more elements of common culture that need not be specified, but may include religion, customs, or language; unique community of interests, feelings and actions; a shared sense of common origins or ancestry, and a common geographic origin (Statistics New Zealand, 2006).

**Standard classification of ethnicity** (Statistics New Zealand, 2006) is a hierarchical classification of four levels. Level 1 of the classification has six categories, level 2 has 21 categories, level 3 has 36 categories and level 4 has 233 categories – excluding residual categories. The 'not further defined' (nfd) categories of level 2, 3 and 4 and the residual categories are not used for collection but are used for coding and output purposes.

**Chinese:** in this paper refers to people who are living in New Zealand, and have a fundamental sense of Chinese cultural values, customs, beliefs, languages and traditions, and regard themselves as a Chinese ethnicity. According to Statistics New Zealand, the Chinese ethnic group is categorised at Level 2, and it can be further broken down to eight different Chinese groups at Level 4 (shown in figure 1).



**Figure 1: The four levels of ethnicity classification**

<sup>1</sup>nfd = Not further defined. A ‘not further defined’ (nfd) category is a type of residual category that is used in hierarchical classification for responses containing insufficient detail to be classified to the most detailed level of a classification, but which can be classified to a less detailed category further up the hierarchy.

<sup>2</sup>nec = Not elsewhere classified. A ‘not elsewhere classified’ (nec) category is a residual category used for responses for which no appropriate category exists. Such responses are usually infrequent or unanticipated. These categories never appear within classifications as stand-alone descriptors, but are combined with descriptors, often taken from a higher level in the classification.

**Ethnic minority group:** is perceived as a sub-ethnic group. For example Chinese is one of the Asian ethnic minority groups. In this case, Asian is the ethnic group of New Zealand society, and Chinese is one of its ethnic minority groups.

**Migrants** in this article refer to people who were born in overseas, and entered New Zealand under an immigration programme. It includes three main categories: Skilled Migrant

Category, Business and Investment Categories, and Family Categories (Immigration New Zealand, 2005).

**The Skilled Migrant Category** is based on a points-pool system, and related to applicant's qualifications, work experience, age, health, character, and English language proficiency to ensure meeting New Zealand labour market's needs. It is the main source of New Zealand migrant category.

**Business and Investment Categories** offer the opportunities for experienced and successful business people who want to develop their new business, and gain residency in New Zealand.

**Family Categories** refer to people come to New Zealand because they already have a family member in New Zealand with New Zealand citizenship and/or residency.

## **Chapter 1: Introduction**

### **1.1. Background: the Chinese in New Zealand**

New Zealand is a multicultural nation of migrants. Within the country, the Asian population, including the Chinese population has grown rapidly in recent years (Statistics New Zealand, 2006). According to the 2006 census, 147,570 Chinese people were living in New Zealand, about 3.6 per cent of the total New Zealand population. Chinese is one of the largest minority ethnic groups, so it has become an important presence in New Zealand society. The fact that more than 78 per cent of Chinese people came from overseas (Statistics New Zealand, 2006) indicates that the majority of them are migrants. A few studies have found that Asian migrants are more likely to be satisfied with their new life in New Zealand, and most of them have better health status compared with other populations in New Zealand (Ministry of Health, 2006a). However, Henderson, Johnston, Trlin, and North's study (2006) showed that Chinese migrants are less likely to report satisfactions about their new life compared to Indians and South Africans, especially at the first two years after migration, due to the significant difficulties in employment. Other studies also indicate that many Chinese migrants experience difficulties in integrating into New Zealand, especially because of social isolation, language obstacles, and the different cultural environment (DeSouza & Garrett, 2005). In reality, those reasons all directly affect their employment and income and, therefore, their quality of life. Many Chinese migrants are under stress from resettlement and regret coming to New Zealand, and all these circumstances contribute to mental illness (Wang, 2000).

As the researcher used to work in a mental hospital as a doctor for 10 years in China, she has strong interests in the mental health field. After migrating to New Zealand, she realised the significant cultural impact on people's mental health. For example, she has experienced difficulties during the adaptation process herself, and also observed some other Chinese people's mental health issues. Interestingly, a few of her friends used to come to her and ask for information about mental health, instead of going to the mainstream services. Before migration, the researcher was impressed by the good social welfare system in New Zealand, and wondered, once Chinese people have mental health problems, and if they seek help, whether they could get enough support from the mainstream services? All these questions stimulated her wish to investigate these issues further.

## 1.2. Mental health issues for Chinese people in New Zealand

According to the World Health Organization, mental illness accounts for 15 per cent of the total burden of disease in the developed world, with depression set to become the second leading cause of disability by 2020 (Murray & Lopez, 1996). In New Zealand, about 47 per cent of people will experience a mental illness and/or addiction at some time in their lives, with one in five people affected in any year (Ministry of Health, 2006c). The *New Zealand Primary Health Care Strategy* has the aim of improving the health of New Zealanders and, in particular, tackling inequalities in health (Ministry of Health, 2001), but despite being the third largest population group (Statistics New Zealand, 2006), Asian people's mental health issues have not been given much attention. Although, in the last decade, more and more research into Asian health has taken place, there is still lack of population-based information, especially on sub-groups (Kumar, Tse, Fernando, & Wong, 2006). Due to the fact that many important studies did not break the research down into the sub-Asian groups, Chinese people's specific mental health needs might be overlooked under the averaging effect.

Moreover, culture has an important impact on people's (patients, families and health providers) understanding of mental health, and it can affect various aspects of the illness process, including illness definition, help-seeking behaviour, response to treatment, and post-treatment adjustment. As Weare said:

Mental health is socially constructed and socially defined: different professions, communities, societies and cultures have very different ways of conceptualizing its nature and causes, determining what are mentally healthy, and deciding what interventions is appropriate (Weare, 2000, p. 13).

A few studies have explored mental health issues for Chinese migrants and described the perspectives of Chinese mental health patients. Some insight from studies from Chinese perspectives indicated that Chinese people have very different cultural perspectives on mental health, and stigma toward mental illness commonly exists among Chinese people (Lin, 1981; E. Ng, 2009; J. Ng, 2003; Peterson, Barnes, & Duncan, 2008). In addition, a few studies demonstrated that Chinese people are under-users of services (Asian Public Health Project Team, 2003), especially mental health services (Ministry of Health, 2009a). In Ngai, Latimer, and Cheung's study (2001), mental health providers reported that it was hard to understand patients' socio-cultural background, and decide what is normal and abnormal behaviour and beliefs in their ethnic communities. Under these circumstances, Chinese people's mental

health issues are possibly under-represented in mental health research in New Zealand. Although, there has been some research from the perspective of Chinese people with mental health issues, little research has investigated how mental health providers perceive and support their Chinese clients in New Zealand. Therefore, this is a priority area for research.

### **1.3. Research question**

How do health providers perceive and support mental health needs of Chinese patients in Christchurch?

As Chinese people with mental health problems are not often seen in clinical settings, the descriptive qualitative research method was chosen via semi-structured face-to-face interviews to describe how health providers perceive Chinese people's mental health and service use issues in Christchurch. Through the study, these issues might be better understood, and therefore offer directions for further health services improvement and future research.

### **1.4. Structure of this paper**

This paper consists of three main parts. The first (Chapter 2) is a review of the literature to provide an overview of the current situation of Chinese people and their mental health issues in New Zealand. A stocktake of mental health services provides information on available health services in Christchurch. The second part (Chapter 3 and 4) is research into provider perspectives on Chinese people's mental health and health service issues. Chapter 3 explains the rationale for the selection of a qualitative research approach and the methods used; Chapter 4 presents findings. The third part (Chapter 5) offers a conclusion and discussion of these findings, indicates the strengths and limitations of the study, and provides recommendations for the future (Chapter 6).

## **Chapter 2: The Chinese people's mental health and service use issues in New Zealand**

### **2.1. Aim**

In this literature review, mental health and service use issues of Chinese people in New Zealand will be examined. A social demographic overview will introduce Chinese people's background in New Zealand especially Christchurch, and then review their mental health and service use issues. Existing mental health information in Chinese languages, the availability of Chinese health providers, and important Chinese initiatives will also be set out. In doing this, the key problems of Chinese people's mental health will be identified. In addition, the stocktake of mental health services in Christchurch indicates the type of support the Chinese people can get from the services.

### **2.2. Background to Chinese people in New Zealand**

Chinese is a distinctive, significant ethnic minority group in New Zealand, and former settlers can be traced to 1865, when the gold seekers came to Otago from South China (J. Ng, 2001). After 1986, as a consequence of changes to New Zealand immigration policy, more and more Chinese people came here from a wider range of places in Asia, including Mainland China, Hong Kong, Cambodia, Malaysia, Singapore, Vietnam, and Taiwan, with China the dominant place of origin. In 2006, the People's Republic of China was the second most common overseas birthplace of all migrants, compared to the fourth in 2001 (Statistics New Zealand, 2006).

Moreover, Chinese people are most likely to come to New Zealand under the Skilled Migrant, Business and Investment, and Family categories. According to the Department of Labour (Department of Labour, 2008), around 46,000 people migrate to New Zealand each year. Of these, nearly 60 per cent came through the Skilled/Business stream. Moreover, Asia was one of the major sources, because about 32 per cent of skilled migrants were from Asia, second only to the United Kingdom/Ireland which was at 36 per cent (Department of Labour, 2008). China, as an important country in Asia, was itself a significant source of skilled migrants. In 2009, migrants from China ranked second of the top five source countries at 13



per cent in New Zealand (Department of Labour, 2009). The Department of Labour (2006/07), pointed out “over the last five years, migration from the UK and China has been predominantly through the Skilled/Business stream”.

### **2.2.1. Why do people choose New Zealand as their second home?**

According to *Life in New Zealand: Settlement Experiences of Skilled Migrants Results from the 2008 Survey*, beauty, nature, relaxed lifestyle and a green and clean environment were in general the main reasons for people to come to New Zealand (Department of Labour, 2008). In the survey, Asian migrants were likely to be attracted by New Zealand’s education system or the educational opportunities for themselves or their children, the political stability, freedom and lack of corruption. Furthermore, another study (N North, Trlin, & Henderson, 2004) showed that the reasons for Chinese people leaving their home country were: a lack of opportunities, wanting a change/challenge, environmental factors, and for political/institutional reasons. They all believed that they would have a better quality of life in New Zealand.

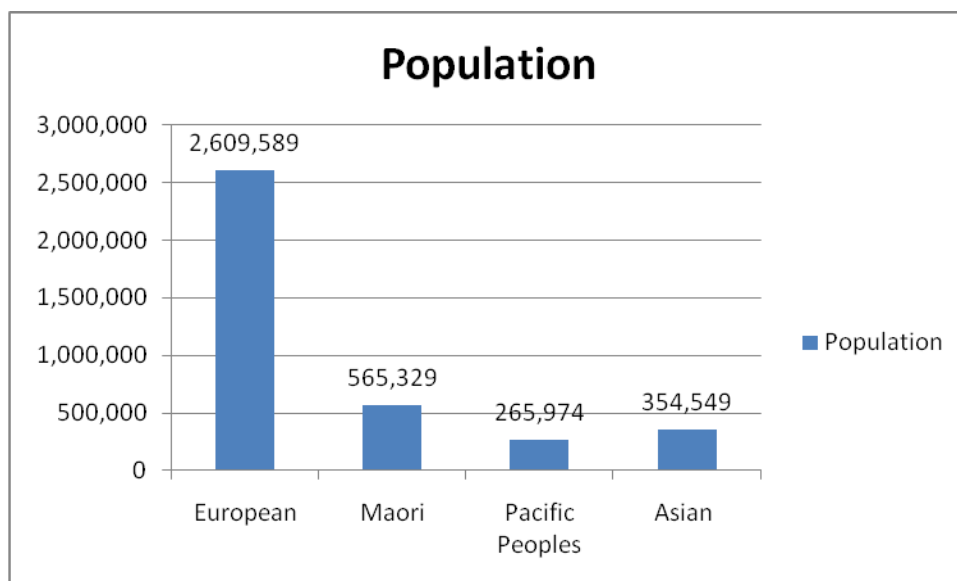
### **2.2.2. Social demography of Chinese people in New Zealand**

According to Statistics New Zealand (2006), approximately 4,027,947 usual residents were living in New Zealand in 2006, and the total population had increased 11.3 per cent compared to 2001. Within the nation, the Asian population was one of the fastest growing ethnic groups, and it had increased almost 50 per cent in five years (from 238,176 in 2001 to 354,552 in 2006) and doubled in 10 years (173,502 in 1996) (Table 1). In 2006, it was the third largest ethnic group in New Zealand, behind only European and Maori groups, but ahead of Pacific groups (Figure 2). Moreover, Chinese was the largest Asian ethnic minority group, with about 147,570 people living in New Zealand (Figure 3). Furthermore, nearly 80 per cent of Asian or 78 per cent of Chinese were born overseas (Table 2), indicating that most Asian/Chinese were migrants, with the number of new migrants increasing dramatically between 2001 and 2006 (Statistics New Zealand, 2006).

**Table 1: New Zealand, Asian, and Chinese population in 1996, 2001, and 2006 censuses**

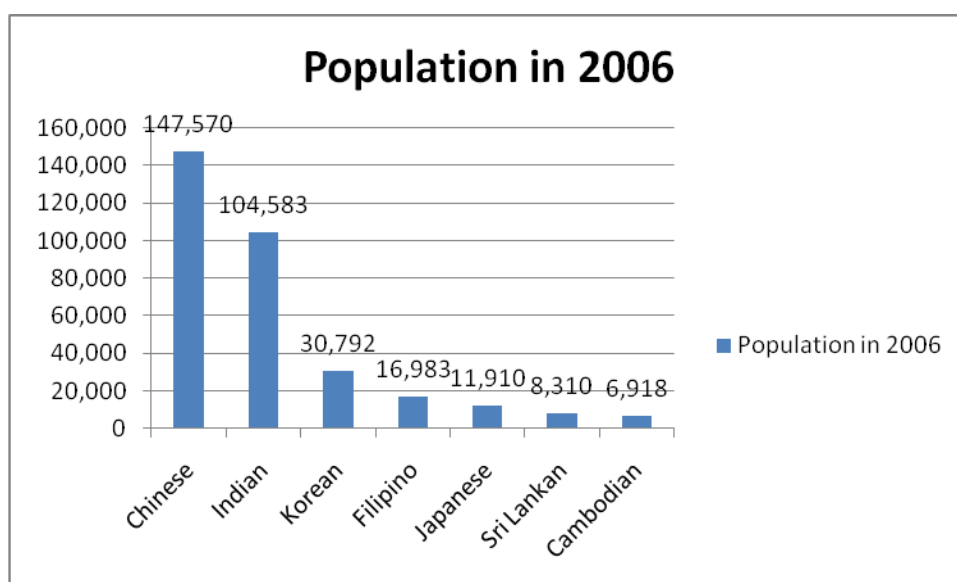
Population			
	1996	2001	2006
Total population	3,618,303	3,737,277	4,027,947
Asian	173,502	238,176	354,552
Chinese	81,309	105,057	147,570

Source: Statistics New Zealand, 2006



Source: Statistics New Zealand, 2006

**Figure 2: Ethnic groups in New Zealand in 2006**



Source: Statistics New Zealand, 2006

**Figure 3 Seven major ethnic minority groups within Asia**

**Table 2: Birthplace of Chinese, Asian, and total New Zealand population, census 2006**

	Chinese		Asian		New Zealand	
Total population	147,570 (146,256)		354,549 (351,696)		4,027,947 (3839760)	
Birthplace	NZ born	Overseas born	NZ born	Overseas born	NZ born	Overseas born
Population by birthplace	32,109	114,147	70,650	281,046	2,960,217	879,543
Percentage (%)	21.95	78.05	20.09	79.91	77.09	22.91

Source: Statistics New Zealand, 2006

### 2.2.3. Chinese people in Christchurch

(The information in this section is drawn from the 2006 census (Statistics New Zealand, 2006), and Christchurch City Council's migrants report (Thorpe, Marr, & Richardson, 2007))

#### 2.2.3.1. Population

In 2006, Christchurch was home to 8.7 per cent of the total New Zealand population, and it was the second largest district of New Zealand. There were approximately 161 different ethnic groups living in this city of about 348,435 people, and the population had increased 7.5 per cent since 2001 (Thorpe, et al., 2007). In Christchurch, Asians (total 26,631 people) were the second largest ethnic group, (compared to the third place at a national level) among European, Maori, Pacific, and Asian groups (Figure 4). In addition, Chinese were always the largest Asian minority group, even though there were fluctuations. Since 1992, China gradually became an important source country of new migrants in Christchurch. Especially during the first few years of the present decade, it was the largest source country of migration for citizens of all nationalities, with 1,209 people arriving in 2003 (Figure 5). However, after 2004, the number of people arriving from China decreased dramatically due to the New Zealand immigration policy, and 2005 saw the lowest level of migrants, with the arrival of only 43 people (Figure 5). The following year, 2006, was similar with England (1,058 people), Japan (504 people), and Australia (190 people), the three largest countries of origin. At the same time, China dropped down to the eleventh largest source country of the migration, with just 55 people, with the reason for the reduction reported as “the negative publicity about English language schools in New Zealand in 2003” (Thorpe, et al., 2007, p. 30). Nevertheless, Chinese people were still the largest of six ethnic minority groups, with 12,477 people (11,715 people from China) (Table 3). Between 2001 and 2006, the Chinese ethnic group increased by the largest number, (3,849 people) of any ethnic group in Christchurch.

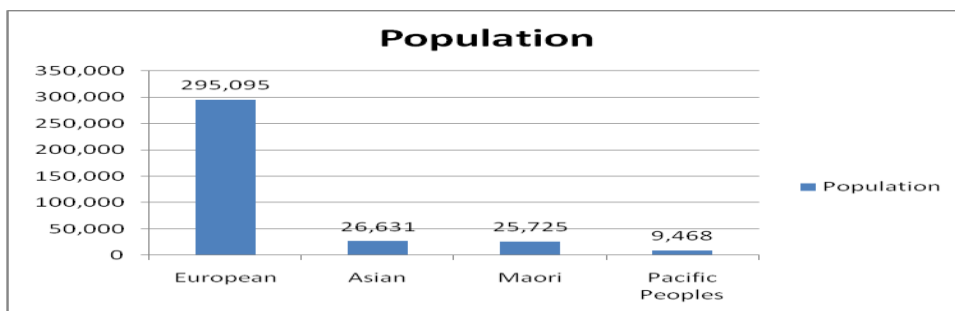
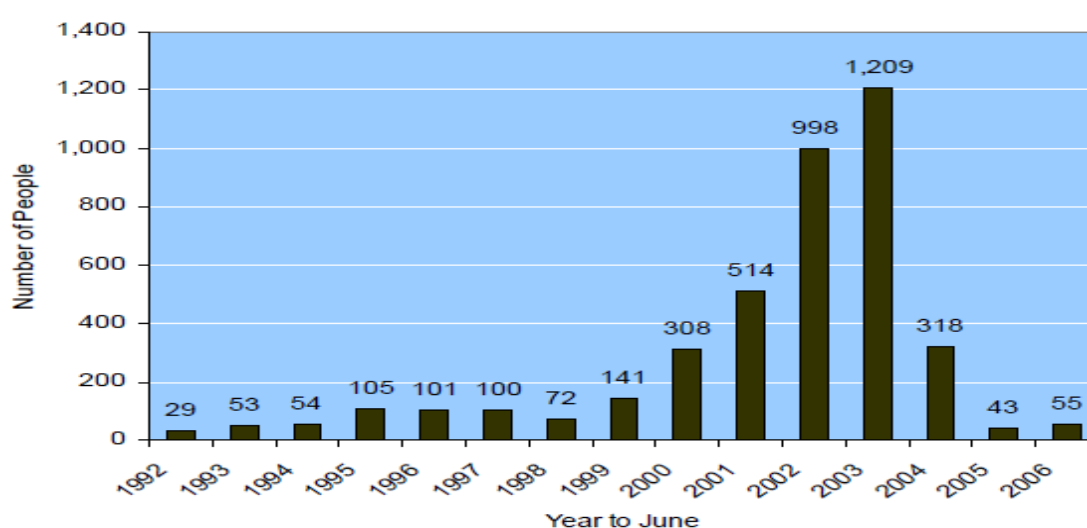


Figure 4 Ethnic groups in Christchurch in 2006

**Table 3: The largest six ethnic groups in Christchurch in 2006**

No.	Largest 6 groups			
	Ethnic groups in level 3	Population	Ethnic groups in level 4	Population
1.	Chinese	12,480	Chinese nfd	11,715
2.	British and Irish	8,697	Samoan	6,105
3.	Samoan	6,405	Korean	4,566
4.	Korean	4,566	English	3,561
5.	Indian	3,057	Dutch	2,835
6.	Dutch	2,835	Indian nfd	2,817

(nfd = 'Not Further Defined' is a residual category for responses that cannot be coded to the most detailed level of the classification but can be coded to a higher level of the classification)



<sup>1</sup> This data is for citizens of other nationalities only and does not include migrants of New Zealand citizenship.

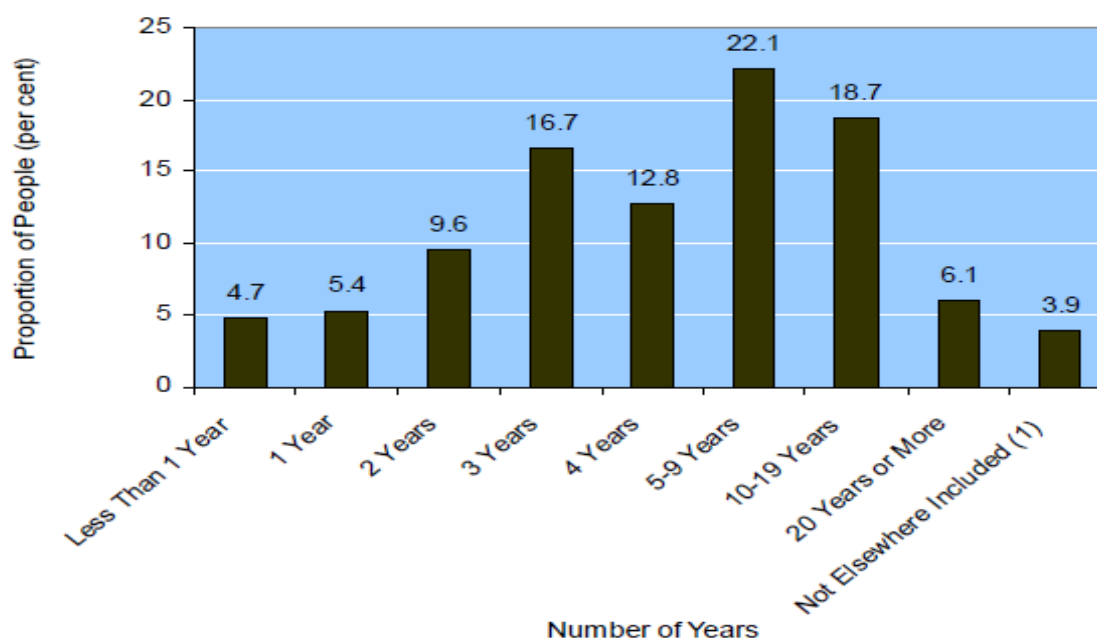
Source: Thorpe et al (2007) based on external migration of Statistics New Zealand

**Figure 5: Migration<sup>1</sup> from China to Christchurch 1992 – 2006**

### 2.2.3.2. Age structure

The median age of Christchurch residents was 36.4 years (Thorpe, et al., 2007), compared with 35.9 years in New Zealand as a whole in 2006 (Statistics New Zealand, 2006). Nevertheless, Christchurch has an ageing population, with approximately 13.5 per cent of Christchurch residents aged 65 years and over, compared with 12.3 per cent of the total New Zealand population. Nearly 19 per cent of people were under 15 years, compared with 21.5 per cent for all of New Zealand. Under this circumstance, the Asian population played an important role in slowing down the ageing of the population, because nearly one in every three Asian was aged between 15 and 29. That means most Asians were young adults. In addition, compared with the British and Irish ethnic groups, the Chinese ethnic group had a much younger age composition, a major reason being the flow of new migrants. The fact that

nearly fifty per cent (49.2%) of Chinese people in Christchurch have been living in New Zealand less than four years (Figure 6) confirmed this (Thorpe, et al., 2007). Moreover, the Chinese population increased in nearly all age groups (except 15 to 19 years) and, especially, the proportions of Chinese young adults grew strongly between 2001 and 2006. For instance, the people aged 20-24 years increased by 2,151, which was about 167 per cent, and the 25-29 year age increased by 993, about 169 per cent.



<sup>1</sup> 'Not Elsewhere Included' is a residual category and includes responses such as 'not stated', 'response outside scope', 'responses unidentifiable', 'refused to answer' and 'don't know'.  
Source: Statistics New Zealand, 2006 Census of Population and Dwellings.

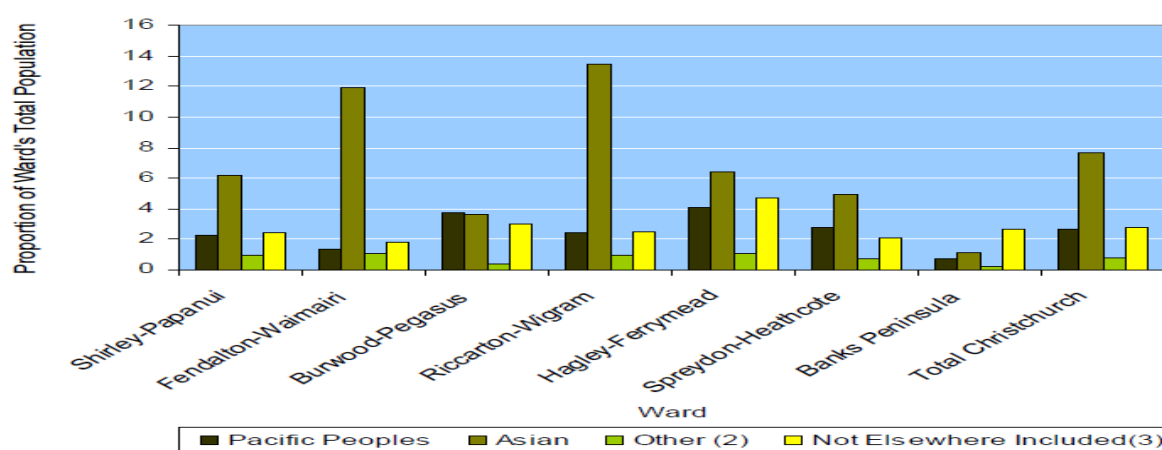
Source: The Migrants Report 2007 (Thorpe, et al., 2007)

**Figure 6: Chinese ethnic group (level 3) – number of years since arriving in New Zealand**

### 2.2.3.3. Where do they live?

Christchurch (including seven wards) is one of the most attractive cities for Asian people to live in, especially in the South Island. The Riccarton-Wigram Ward had the largest population of Asians, with 8,208 people (13.5 per cent), and the Fendalton-Waimairi Ward had the second largest composition of Asians, with 6,303 people (11.9 per cent) (Figure 7) (Thorpe, et al., 2007). In the city, the Chinese population was more likely to locate close to education services. For example, areas around the Christchurch Polytechnic, the University of Canterbury, and the former Christchurch College of Education had high proportions of Chinese residents, ie in the Central City Census Area Unit of Cathedral Square, and in northwest Christchurch in Riccarton, Riccarton West, and Wharenuui, and Upper Riccarton (Figure 8) (Thorpe, et al., 2007). In addition, Chinese was the largest ethnic minority group in

the Riccarton-Wigram Ward, with 4,878 people. It also consisted of 18.6 per cent of the total population in the Riccarton West Area Unit. Moreover, Chinese (3,141 people), and Korean (1,497 people) were the two largest ethnic minority groups in the Fendalton-Waimairi Ward. In the Shirley-Papanui, and Spreydon-Heathcote Wards, the Chinese ethnic minority groups (with 1,281 people, and 1,185 people) were the second largest groups, only behind the British and Irish ethnic groups (with 1,494 people, and 1,326 people). Hagley-Ferrymead Ward had the third largest population of Chinese, while Burwood-Pegasus Ward, and the Banks-Peninsula Ward were the least likely places for Chinese to live (Thorpe, et al., 2007).



<sup>1</sup> Includes all the people who stated each ethnic group, whether as their only ethnic group or as one of several ethnic groups. Where a person reported more than one ethnic group, they have been counted in each applicable group.

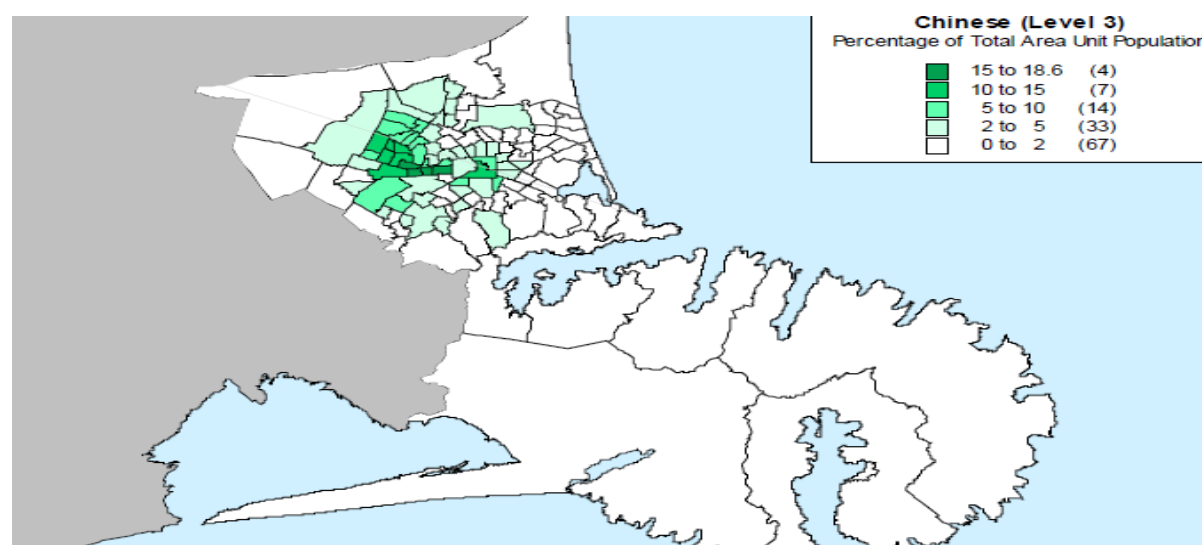
<sup>2</sup> The 'Other' category in this graph excludes 'New Zealanders'.

<sup>3</sup> Not Elsewhere Included is a residual category and includes 'not stated', 'response outside scope', 'responses unidentifiable', refused to answer' and 'don't know'.

Source: Statistics New Zealand, 2006 Census of Population and Dwellings.

Source: The Migrants Report 2007 (Thorpe, et al., 2007)

**Figure 7: Proportion of the total population by ward in ethnic groups (level 1), in 2006 total responses<sup>1</sup>**

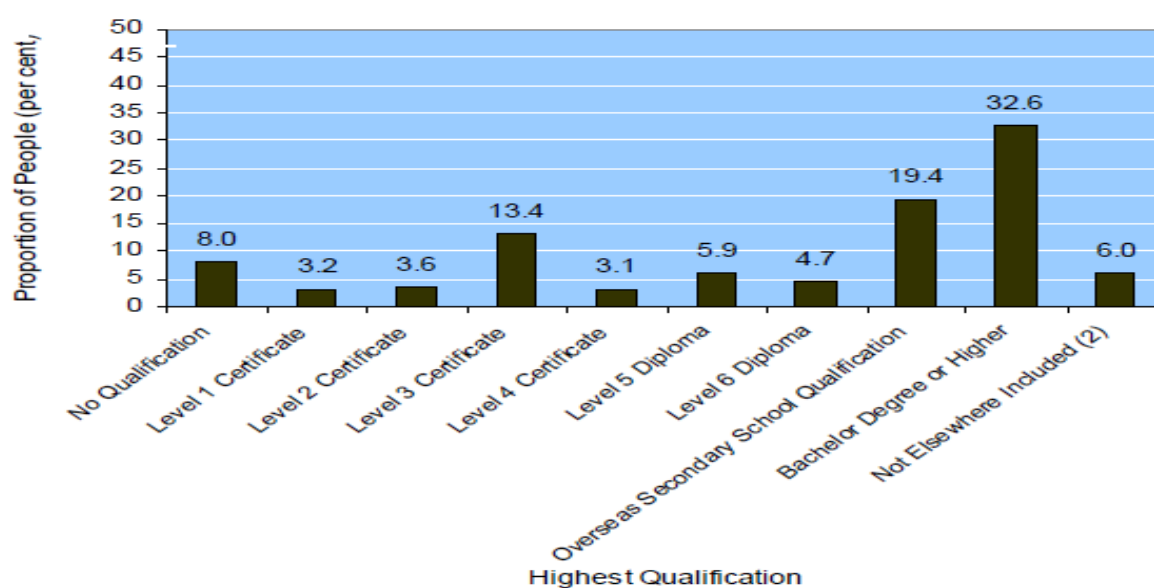


Source: The Migrants Report 2007 (Thorpe, et al., 2007)

**Figure 8: Chinese ethnic group (level 3) by Area Unit, in 2006**

### 2.2.3.4. Education

Compared with the national average, Christchurch people have a slightly better educational status with about 76.6 per cent of Christchurch people aged 15 years and over with formal qualifications, compared with 75.0 per cent for New Zealand as a whole (Thorpe, et al., 2007). Nationally, the Asian group had the highest proportion of people with a qualification (88 per cent), followed by the Middle Eastern/Latin American/African ethnic group at 86 per cent, and the European ethnic group at 75 per cent (Statistics New Zealand, 2006). The Asian group also had the highest rates of participation in study (33 per cent), followed by the Middle Eastern/Latin American/African ethnic group (32 per cent). In Christchurch, people who belonged to a minority group were more likely to hold a Bachelor or higher degree at 24 per cent, compared to 19.4 per cent for the general population in 2006 (Thorpe, et al., 2007). Moreover, only 11.4 per cent of the total ethnic minority groups had no qualification, compared to 16.2 per cent of the total Christchurch population. Similar to the national situation, people belonging to the ethnic minority groups were more likely to attend a formal education than the Christchurch population as a whole. Furthermore, Chinese people tended to have a good education in general. For instance, 32.6 per cent of people aged 15 years and over had a Bachelor or higher degree, compared to 24.0 per cent for the total ethnic groups, and 19.4 per cent for the entire Christchurch population in 2006 (Figure 9) (Thorpe, et al., 2007).



<sup>1</sup> For the population aged 15 years and over.

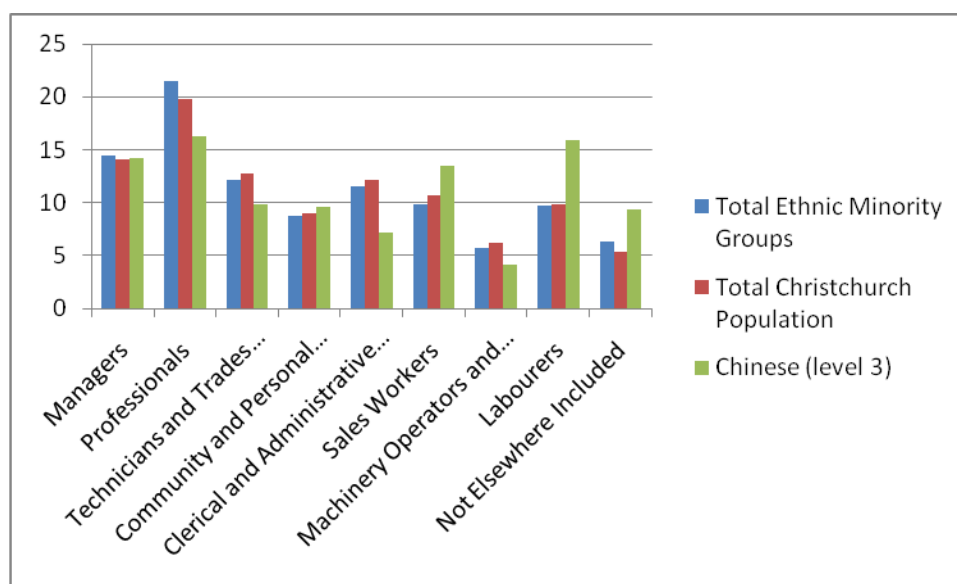
<sup>2</sup> 'Not Elsewhere Included' is a residual category and includes responses such as 'not stated', 'response outside scope', 'responses unidentifiable', 'refused to answer' and 'don't know'.

Source: Statistics New Zealand, 2006 Census of Population and Dwellings.

Figure 9: Chinese ethnic group (level 3) – highest qualification gained, in 2006

### 2.2.3.5. Employment

People in Christchurch had a lower unemployment rate (4.5 per cent) for people aged 15 years and over, compared to the national status (5.1 per cent) in 2006 (Thorpe, et al., 2007). However, in this city, people from ethnic groups had a higher unemployment rate (7.9 per cent), and the Chinese had the highest unemployment percentage which was 11.7. In the report, the high rate of unemployment was not influenced by the large number of Chinese students, because Chinese people who are on study were classified as ‘not in the labour force’, and excluded from the analysis of unemployment rate. In the workforce, professionals and managers were the two most common occupations in general, and people belonging to the ethnic groups were more likely to be the professionals or managers than the total Christchurch population (Figure 10). However, although 'Professionals' was also the most common occupation for Chinese people, which is similar to the population as a whole, the percentage (16.3 per cent) was much lower than the level of total minority groups (21.5 per cent), and total Christchurch population (19.8 per cent) (Figure 10). In addition, labourers (15.9 per cent), managers (14.2 per cent), and sales workers (13.5 per cent) were three other common occupations for Chinese people (Figure 10). In the other main occupation groups, the Chinese ethnic group were similar to other ethnic groups and the total population (Figure 10).



- For the population aged 15 years and over.
- Not Elsewhere Included is a residual category and includes responses such as ‘not stated’, ‘response outside scope’, ‘responses unidentifiable’, ‘refused to answer’, and ‘don’t know’.
- Total Ethnic Minority Groups include 26,622 people who were classified in the ‘Other Ethnicity group’. Within Christchurch, 93.5 per cent of the total population of the ‘Other Ethnicity’ group were classified as ‘New Zealanders’.

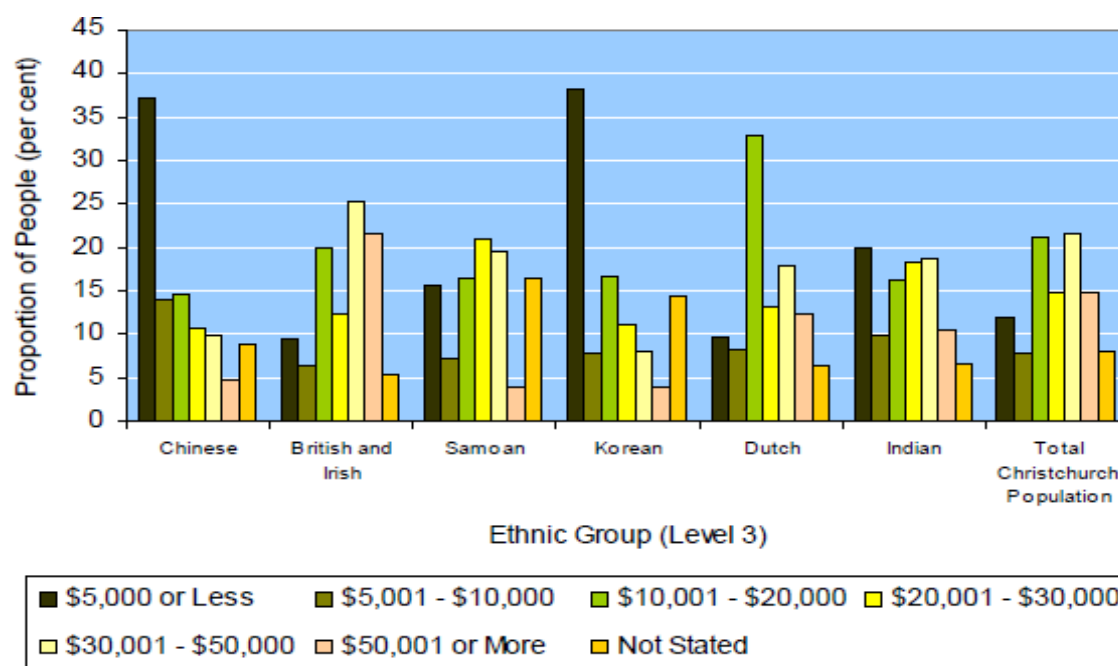
Source: Christchurch City Council’s migrants report (Thorpe, et al., 2007)

**Figure 10: Occupations in Christchurch in 2006**



### 2.2.3.6. Income

In Christchurch city, the median annual income per person was about \$23,400 for people aged 15 years and over, compared with a median of \$24,400 for all New Zealand in 2006. Nationally, Asians had the lowest median annual personal income group (\$14,500 per year) compared with European (\$25,400) and the other New Zealanders (\$31,200). Moreover, it was worse than Maori people (\$20,900 per year), and Pacific people's income (\$20,500 per year). This situation existed in Christchurch because British and Irish groups had the highest median total personal income, which was \$29,600 annually, following by the Australian ethnic group which was \$29,300, but Asians tended to be the lowest income group compared with other ethnic groups. In 2006, the four ethnic groups with the lowest median annual total personal income in Christchurch were Japanese (\$11,100), Other Asian (\$10,400), Chinese (\$8,000), and Korean (\$7,900). The low income status might partly due to the high proportion of Chinese people who are students. Moreover, the reduction of personal income, and the negative growth rate of spending power between 2001 and 2006 demonstrated the poor living standards for this group. For example, in 2006, a large number of Chinese people (37.1 per cent) earned less than \$5,000 annually (Figure 11).



<sup>1</sup> For the population aged 15 years and over.

<sup>2</sup> Total Personal Income data needs to be interpreted with caution due to the high rates of non-response ('Not Elsewhere Included'). 'Not Elsewhere Included' is a residual category and includes responses such as 'not stated', 'response outside scope', 'responses unidentifiable', 'refused to answer' and 'don't know'.

<sup>3</sup> Includes all the people who stated each ethnic group, whether as their only ethnic group or as one of several ethnic groups. Where a person reported more than one ethnic group, they have been counted in each applicable group.

Source: Statistics New Zealand, 2006 Census of Population and Dwellings.

Figure 11: Annual total personal income<sup>1,2</sup>, in 2006 (total responses<sup>3</sup>)

## **2.3. Mental health and service use of Chinese people in New Zealand**

### **2.3.1. Overall mental health status and service use of Chinese people**

People of Chinese ethnicity are commonly regarded as a healthy, well adjusted, and a safe community in New Zealand. According to the Asian Public Health Project Team's report (Asian Public Health Project Team, 2003), the health status of Asians overall is good, and specifically among the Chinese population (Abbott, Wongoe, Williams, Auoe, & Young, 2000). For example, Chinese, Indian and Other Asian ethnic groups' avoidable mortality is much lower than the total population (Asian Public Health Project Team, 2003). Chinese and Other Asians have significantly lower ambulatory-sensitive hospitalisation rates than the total population (DeSouza & Garrett, 2005). Moreover, Chinese people are more likely to have a longer life expectancy, and lower rates of crime and divorce (Statistics New Zealand, 2006). In this situation, the New Zealand migration policy is playing an important role: applicants' health has to meet the specific standards for migration (McDonald & Kennedy, 2004). Therefore, most people at least have generally good physical health prior to migrating.

A wide range of factors have been identified which may affect people's mental health, including genetic predisposition, previous medical history, the physical and social environment and the availability of health services. Although the good physical health status has been ensured prior to migrating, the mental health status is hard to examine during the migration process. In New Zealand, two major issues which may affect Chinese people's mental health have been explored by a number of studies: one is the adaptation related problems and the other is the low utilisation of mental health services. For example, Ho, Au, Bedford, and Cooper's study (2003) found high risk factors and higher levels of psychological disturbance among Chinese migrants who were born in China, came to New Zealand under the family or family reunion category, spoke English infrequently, and had resided in New Zealand for 10 years or more. Henderson, Pernice, Skinner, Trlin, and North's study (2009) reported that a potential high mental health risk exists among recent skilled migrants, especially because of particular difficulties associated with employment among Chinese migrants in the first two years after migration. In addition, even though *The New Zealand Primary Health Care Strategy* already aims to improve the health of all New Zealanders and, in particular, to tackle inequalities in health (Ministry of Health, 2001), it has emphasised Maori people and Pacific people's health. As an important ethnic minority group, Chinese people's mental health issues have not been given enough attention. For instance, as

Kumar et al. (2006) stated, with the Asian population growing rapidly in the previous decade, the mental health needs of Asian migrants have not been adequately met, especially as only small population based studies have been undertaken related to Chinese.

### **2.3.2. 'Asian' is not an appropriate term to represent Chinese health**

More than 30 different Asian ethnic groups live in New Zealand, and the most common are Chinese, Indian, Korean, Filipino, Japanese, Srilankan, and Cambodian (as stated in section 2.2). A few studies demonstrate that among Asian groups, health status varies between the sub-groups (Asian Public Health Project Team, 2003; Rasanathan, Ameratunga, & Tse, 2006). For example, cardiovascular disease and type-II diabetes are frequently high among Indian peoples, but poor utilisation of health services is a major issue among Chinese. According to the Youth 07, Chinese secondary school students were less likely to report good health compared with European students, whereas there was little difference between Indian students and Europeans (Parackal et al., 2007). Therefore, Rasanatha, Craig, and Perkins (2004) argued that use the term of "Asian" in the health research field may result in an averaging effect, and the high health needs of particular groups are possibly overlooked. An example was given that the young structure of the population may mask the rates of hospitalisation and death among older Asians.

Especially in mental health settings, people's cultural background is of considerable importance. Religion, language, education and socio-economic experiences may influence the perspectives of normal and abnormal, and how people approach mental health services. In reality, even though similarities do exist among 'Asians' due to the migration background, beyond the mask of 'Asian', the values and assumptions are very different from each other. For instance, Chinese Indian and Koreans are more likely to have a higher education, and they have usually come to New Zealand under the New Zealand immigration policy, while Cambodians and Vietnamese have more commonly come to New Zealand as refugees (Ho, et al., 2003). Moreover, about half of the Chinese people reported that they had no religion, one-quarter were Christians and approximately 1 in 7 were Buddhists. While Hinduism is the most common religion for Indians, Christianity is the most common for Koreans, and Buddhism is the most common religion for Cambodians and Vietnamese.

Thus, even though the term 'Asian' clusters a group of people originally from Asia, it is not appropriate for representing people's health status, and Chinese people's mental health needs are possibly under recognized.

### **2.3.3. Prevalence of mental illness**

The New Zealand Mental Health Survey 2006 (Ministry of Health) showed that about 47 per cent of New Zealanders will experience a mental illness and/or addiction at some time in their lives, with one in five people affected within any year. However, there is little population-based research into mental illness in Chinese people (Kumar, et al., 2006). Therefore, it is hard to estimate Chinese-population based prevalence information on mental health, especially as the New Zealand Mental Health Survey was only able to break down data by Maori and Pacific ethnicities (Browne, Wells, & Scott, 2006).

Some small population based studies demonstrated levels of mental health problems similar to those in the general population. For instance, an Auckland study in 1999 including 271 Chinese migrants did not find major adjustment problems among Chinese people (participants were mainly from Taiwan and Hong Kong), and the psychiatric morbidity was 19 per cent (Abbott, Wong, Williams, Au, & Young, 1999). A survey of 127 Chinese women from Dunedin found that the overall rate of minor mental disorders among this population (21 per cent) did not differ from their European counterparts (P. Cheung & Spears, 1992). Another Dunedin prevalence study of mental disorder did not find any difference between foreign-born Chinese women and the local-born women (Abbott, et al., 2000). In 2003, a study of 162 Chinese migrants aged 55 or older found 26 per cent of participants met criteria for depressive symptomatology (Abbott et al., 2003). DeSouza and Garrett (2005) and also indicated that Chinese and other Asian males have significantly lower suicide mortality rates than the total population.

From the above studies, it is clear that even though more studies have researched Chinese health in the recent decade, there is still lack of population-based evidence on Chinese people's mental health issues in New Zealand. However, these studies report a similar level of mental health needs compared Chinese with the general population.

### **2.3.4. Sources of stress for Chinese people's mental health**

In spite of a good mental health status among Chinese on the surface, in reality many Chinese people experience hardship during the resettlement, with migration related problems contributing to Chinese people's problems with mental health and their quality of life. Ho, Au, Bedford, and Cooper (2003) challenged the stereotypes of extraordinary well-being and mental health among Asians on the basis that inefficient English skills, social isolation and poor employment status would undermine exceptional health. Moreover, once they have

health needs, accessible health services are essential for quality of care for Chinese people in New Zealand. In addition, a particular pressure for Chinese elders has been identified as due to their dependent living pattern, including relying on the young people for translation and transportation. All these factors combine together and lead Chinese people to lose confidence, to regret coming to New Zealand, and experience risk factors for mental illness.

#### **2.3.4.1. The stress of migration**

Surviving in a new country is stressful, especially for people from a different cultural background. A number of studies have explored the relationship between migration and health, and indicated that the potential health risk factors for migrants are very complex, and often associated with cultural background, previous health history, and the accessibility of the health care system (Henderson, et al., 2009; Manuel & Mourtala, 2005). Moreover, studies also demonstrated that migration itself may contribute to mental health, especially the different social environment. For instance, Chinese migrants are often under stress from poor English skills, unemployment/under-employment, family separation, inadequate social support, negative public attitudes and rejection (Kudos Organisational Dynamics Ltd, 2000). These circumstances are all risk factors of mental illness.

#### ***Cultural differences***

The centuries-long history of Chinese civilization influences its people's beliefs, behaviours and social relationships, and there are many differences from and conflicts with the Western-styled New Zealand. As Ng (2003) described, in traditional Chinese culture people are more likely to be family or group orientated, and focus on advancing their children in education. It might be one of the reasons for Chinese people choosing to live close to education institutions (see section 2.2). Chinese parents are expected to offer the best start in their children's life, and take responsibility for their children for longer. Then, the children are expected to work hard to achieve, and reciprocate by taking care of their parents in their old age. Therefore, Chinese people are structurally stable. Western culture, however, is more likely to promote the individual and change. In the western family, the relationships between the family members are much looser, and they tend to be friends between the generations. Western children have a tendency to leave their family earlier, and choose their own careers themselves, and their parents are more flexible, and supposed to support their children's choice in a wide range of different things. Other distinctive elements of Chinese culture include the avoidance of direct 'no', the walking away from potential argument, conflict or confrontation, a low profile, the hiding of one's strengths, the deprecation of one's success,

therefore it is more pacific and passive than Western civilisation. These characteristics lead to specific behaviour and mannerisms, and these differences may lead to cultural conflicts for Chinese migrants, and create stress for their mental health after the migration.

### ***Language difficulty***

Language is one of the main factors which affect Chinese people settling in New Zealand. According to Statistics New Zealand (2006), the majority of people unable to speak English were born overseas (80.3 per cent). As a result of inefficient language skills, Chinese people may have difficulty integrating with local people and finding a suitable job in the labour market. Particularly in health care settings, language skills directly affect Chinese people's use of health services. For example, inefficient language skills might cause patients to become emotionally agitated, frustrated, upset, and lack confidence in the service (Ngai, et al., 2001). Therefore, poor language skills may result in the low utilisation of health services and loss of follow up. In the clinical settings, the health providers also indicated that communication with non-English speakers could be time consuming and make them feel stressful and frustrated (Nicola North, Lovell, & Trlin, 2006). Ng (2003) indicated that even highly skilled Chinese migrants may not be familiar with medical terminology, and this situation may be even harder for those with mental health problems. It may affect the efficiency of health assessment, and lead to a misunderstanding and even a wrong diagnosis (Ngai, et al., 2001).

### ***Social isolation***

Social isolation is another big problem affecting how well the new Chinese settled. After coming to New Zealand, people tend to be isolated. The fact that they are far from their relatives and friends back in the home countries means they lack emotional support in the new social environment. Poor local knowledge is another problem when seeking appropriate support in the new country. For instance, about 56.1 per cent of Asians did not know where/how to seek information/services (DeSouza & Garrett, 2005). Moreover, 50 per cent of Chinese migrants did not report a religion, or belonging to any community (Ho, et al., 2003). About 75 per cent of Chinese migrants reported adapting to the new environment, and overcoming difficulties by themselves, and the support from relatives, church and community organisations were less frequently mentioned (Abbott, et al., 2000). Wang (2000) pointed out that difficulties particularly exist for the people who come from a traditional religious background and with limited English language, because they have to cope with considerable

social and cultural isolation in their new country. Homesickness and isolation, together with inadequate social support, become a big pressure in their new life.

### ***Socio-economic related factors***

Studies have demonstrated that there is an interaction between socio-economic status and health outcomes (Henderson, et al., 2009); people with low incomes are likely to have poorer health (Chiu & Lacey, 2004; N North, et al., 2004). Especially, evidence shows a higher rate of depression, anxiety, and suicide among unemployed people (Bartley, 1994; Rose, Hatcher, & Koelmeyer, 1999; Shortt, 1996), and therefore, having a secure job is essential for a good quality of life. However, in the new environment, Chinese people often experience difficulties with employment. Even though Chinese people in the labour market are likely to be highly skilled, well educated, very experienced, and hard workers, they are likely to have a lower income, and a higher unemployment rate (see section 2.2). The main barriers were identified as lack of good English communication skills, lack of knowledge of the local labour market, lack of local qualifications and work experience, and discrimination from employers (Department of Internal Affairs, 1996; Department of Labour, 1998). Particularly, unemployment may affect people's mental health. North, Trlin and Henderson's study (2004) reported that after three years in New Zealand, associated with the greatest difficulty in the labour market, more illness episodes were reported by Chinese people.

#### **2.3.4.2. Stresses from the unfamiliar health system**

Lack of understanding of the structure of the New Zealand health system also affects Chinese migrants using health services (DeSouza & Garrett, 2005). Back in China, the health care system is very different from New Zealand's appointment-based and primary health care-based system. Currently in China, people go directly to the hospital for every health need (Michael & Moreton, n.d). They can choose any hospital they like and go there at any time. It is not necessary to make an appointment or be referred by a general practitioner (GP). Most Chinese patients prefer to wait for a while to see a doctor within a day, rather than make an appointment to see a GP a few days or a few weeks later. Moreover, this is one of the major reasons for delaying treatment. Most Chinese people also think specialists are more trustworthy and reliable than a GP. Furthermore, it is much easier to see a specialist in China and it is not as expensive as in New Zealand. That is the common and acceptable way for most Chinese people to get medical care in China, and historically they have been very content with this kind of health system.

However, after Chinese people migrate to New Zealand, they may not be aware of the importance of primary health care. Even though people can visit any GP and get reduced fees and cheaper prescriptions using a Community Services Card (CSC) or High Use Health Card (HUHC), they probably do not know that people will only get cheaper general practice fees and prescriptions if they are enrolled with a GP and primary health organisation (PHO) (Ministry of Health, 2007). Moreover, they may not be aware of the differences in the health system, especially most of the time, the ‘simply pop-in’ habit is unavailable and not acceptable. The health providers reported that Asians were the most common patients identified as emergency service respondents (Nicola North, et al., 2006). In the current New Zealand health care system, GPs are the gatekeepers for access to specialist care, and to phone and make an appointment with them first is necessary (Migrants Guide to Christchurch, 2010). In addition, to see a specialist at hospital, a referral from a GP is required, and it may take a few weeks for the referral to take place. Although the public hospital is free, there is likely to wait to get access to specialist health services (Migrants Guide to Christchurch, 2010). The health providers reported that their clients who have migration background are likely to feel frustrated about the unavailability of directly to the specialists and the long waiting time (Nicola North, et al., 2006).

Due to the unfamiliar health system, some Chinese patients might limit the opportunities to see a doctor or go to the other health services, and they probably just expect to recover by themselves. For example, the Asian Public Health Project Team (2003) indicated that 7.5 per cent of Chinese people reported self-medication. Moreover, Youth 07 (Parackal, et al., 2007) pointed out the poor knowledge among Chinese secondary school students. In the survey, 14 per cent of Chinese students were unable to access health care when they needed it in the previous 12 months, and ‘do not know how to get access to health services’ is one of the common barriers.

#### **2.3.4.3. Stresses for Chinese elders**

Elders are the particular vulnerable group in the Chinese population because of their living patterns. Most of them come to New Zealand under the family reunion category, and the reasons of their coming are not only to enjoy the beautiful green environment, but also to support their adult children. For instance, they help young couples to do the housekeeping and cooking, as well as looking after their grandchildren, so that the younger generation can concentrate on their own work. However, after coming to New Zealand, due to the language and cultural barriers, older people have to rely on the younger generation for translation and



transportation. In reality, only 4.8 per cent of Chinese people aged over 65 were living alone (DeSouza & Garrett, 2005), but should their children leave, they would suffer from intense isolation. The sudden change from independent to dependent adults makes them frustrated, and a few studies demonstrated how these specific stressors influence Chinese elders' mental health (Asian Public Health Project Team, 2003; Ho, et al., 2003). In fact, many have experienced loneliness, isolation, anxiety, and a feeling of being marginalised by the host society (Ho, et al., 2003). Even in the new cultural environment, Chinese older people are likely to maintain their own living style, and their adult children and grandchildren's rapid acculturation to the new society make them feel lack of respect and distressed.

Older Chinese people are likely to depend on their children or their grandchildren to communicate outside the family, and their limited language ability becomes one of the major stresses for them. According to Statistics New Zealand (Statistics New Zealand, 2006), among Chinese recent migrants aged 65 years and over, 77 per cent of men and 85 per cent of women could not speak English or Maori, and English is the biggest obstacle for them in making new friends and participating social activities in the new society. In health care settings, without the younger generation's assistance, they may not be able to understand the health provider's instructions, or even make an appointment with the health service. In the mental health services, it would be much harder to describe their feelings accurately and, therefore, misunderstandings may occur.

In addition, a few studies pointed out that older Chinese people are more likely to rely on their children for transport (Ho, et al., 2003). According to the New Zealand Transport Agency (NZTA), less than 1 per cent of Chinese drivers are over 75 years age (shown in Table 4) (New Zealand Transport Agency, 2009). However, it was not possible to calculate rates of license holding for each age group because census data did not permit aggregation according to China born.

**Table 4: Chinese holders of New Zealand driver licence by age**

Age groups	15-24	25-34	35-44	45-54	55-64	65-74	>75	Total
Numbers of drive licence holder	14268	42375	18710	13782	5229	2345	641	97350
Percentage (%)	14.66	43.53	19.22	14.16	5.37	2.40	0.66	100

Source from New Zealand Transport Agency (2009)

Thus, many elderly Chinese have great difficulties gaining access to health, including mental health, services, and reliance on their family members for communication and transport limits their involvement outside the home. If the younger family members do not

have time to take them to a GP, they probably will miss the appointment. Moreover, even though good health services and social services are provided, and they know that the services are available to them, the people who cannot speak independently or go independently may not be able to use them. A study (G. Cheung, 2010) in a community-based old age psychiatry service from Auckland showed that Chinese old people tend to delay in seeking mental health care until their psychiatric symptoms became unmanageable. Therefore, there is a need to pay special attention to the problems and mental health needs of older people within the Chinese population.

### **2.3.5. Chinese perspectives on mental health**

The highly influential ancient Chinese book , *Yellow Emperor's Inner Canon* (or *Huang Di Nei Jing*), has indicated how the way of life, the environment, and the spirit together have contributed to people's mental health for more than two thousand years. For example, a description similar to western medicine's psychiatric Mood Disorder – bipolar, including mania and depression, has been recorded as “Kuang” and “Dian” in the book. For “Kuang”, the patient will have little sleep, absence of hunger, with a boosted ego, be arrogant, laugh in an insane manner, sing, and be constantly active. “Dian” is unhappy, falling to the ground with eyes looking straight ahead (Lu, 1978). Furthermore, Traditional Chinese Medicine is more likely to consider “Kuang” and “Dian” as two different issues, but western medicine is more likely to consider “Mania” and “Depression” as two cycling components of a single disease entity (Lin, 1981).

In reality, many ordinary Chinese people are not familiar with western medicine's concepts of mental illnesses. For example, Ng's study (2009) in China, found that people lack the terminology and knowledge of mental illness in western medicine. None of the patients or family members had heard of bipolar disorder prior to the patient's diagnosis, but some had heard of manic-depression, and more people had heard of depression and schizophrenia. People are also unaware of the necessity for long-term treatment (Ran et al., 2003). A study showed that Chinese patients diagnosed with schizophrenia believed that “full recovery could not be said to have been achieved until they stopped medication” (R. Ng et al., 2008, p. 118). In this circumstance, many patients try to give up the maintaining treatment in order to have an entire recovery. Moreover, sometimes mental illnesses are conceived in Chinese culture as having supernatural causes (Ran, et al., 2003).

Furthermore, shame and ‘face’ issues have been demonstrated in a few studies among Chinese communities. In the article *Fighting Shadows*, Peterson et al (2008) confirmed that

self-stigma and discrimination issues were common among Chinese mental health patients in New Zealand, especially those migrants from rural China. The expressions of negative attitudes are toward mental illness patients by Chinese people, with the negative attitudes drawn mainly from people's childhood, media reports, and other people's negative descriptions of people with mental illness. Thus, 'mad' people are scary, and mental illnesses are unacceptable to Chinese people. Many people try to hide the fact that there is somebody in the family with mental health problems. Consequently, they may be delay seeking mental health care, or be reluctant to use mental health services until disturbed members become unmanageable, and have severe behavioural symptoms (Ran, et al., 2003). Ran's study in rural China found that the main reasons for families seeking help for the patients were:

- The change in behaviour, including bizarre behaviour in speaking (75.7 per cent),
- Violent, aggressive or suicidal behaviour (11.3 per cent),
- Change of routine life including personal hygiene, sleeping and diet (6.8 per cent),
- Impairment of social functioning at school, work, and home (3.9 per cent),
- Complaints of physical discomfort or pain (2.3 per cent).

For relatives, recognition of abnormal symptoms were as follows: 47.7 per cent of their relatives did not know what problem the patients had; 29.7 per cent of relatives thought that something was wrong with the patient's brain; 12.7 per cent believed that the patients thought too much; 7.9 per cent insisted that the abnormal behaviour was caused by ghosts or gods; and 2.0 per cent believed that the patients suffered from physical illness (Ran, et al., 2003). Moreover, not only their families but also patients themselves do not want to accept their mental illness, try to deny it, and sometimes they complain about their physical discomfort, such as body pain, headache, or sleep problems. Moreover, North's study (2006) reported that the perception that 'migrants have a different presentation for their health problems compared with non-migrants patients' is likely to increase alongside the health providers' working experience with clients from different ethnicities in New Zealand. Tse's study (2004) demonstrated that because of the concerns of face and future participation in education, and employment, a Chinese mental illness patient may possibly refuse mental health services.

Therefore, the different understanding of mental health issues, and the poor knowledge among both Chinese families and people with mental illness, may result in a low use of mental health services in New Zealand.

### **2.3.6. Health providers' perspectives on their Chinese clients**

Health providers' attitudes towards their patients have a very important role in supporting their patients to achieve good quality of care. *The Mental Health Commission* (2000) indicated the requirements for mental health practitioners: they have to have a fundamental shift in their attitude, including the level of respect and value towards consumers of the mental health services — reaching out from one human being to another and valuing the person, as a person first, in any interaction or therapeutic relationship. A survey from Australia showed that compared to the general public, health professionals responded more negatively towards people with a mental disorder, and discrimination is more likely (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999). Luoma, Martin, and Pearson (2002) reviewed 40 studies, and found that on average, 45 per cent of suicide victims had contact with primary care providers within one month prior to suicide, three out of four suicide victims had contact with primary care providers within the year prior to suicide, approximately one-third of the suicide victims had contact with mental health services, and about one in five suicide victims had contact with mental health services within the month before their suicide.

One study from New Zealand explored health professionals' views on Asian healthcare needs and services in the North and West Auckland region early this century (Ngai, et al., 2001). Among the 300 health professionals, 48 per cent were European, 32 per cent were New Zealand European, and 13 per cent were Asian, including 8 per cent Chinese. This survey involved a wide range of people, including GPs, nurses, midwives, therapists, community workers, consultants, surgeons, social workers, psychologists, psychiatrists, as well as health providers in management roles. In the results, language was identified as the main barrier for the health workers in providing care to their Asian patients, and cultural difference was considered a major difficulty faced by mental health staff. Miscommunication may lead to inefficient assessment or treatment, and impact on the quality of service. GPs especially found it is challenging to deal with the mental health problems of people from different ethnicities, as they are often the first contact for the patients.

Moreover, from the health providers' views, Asians are more likely to be shy, show high anxiety levels, and not to speak for themselves (Ngai, et al., 2001). Social stigma makes patients or relatives unwilling to seek help. Asians also have different expectations of treatment in that they are more likely than the westerners to expect to be totally cured. In addition, the health professionals indicated that some Asian people's understanding of the

health services in New Zealand is inadequate and, partly due to language barriers, they are easily lost in the follow-up system. The fact that Asians are less likely to have a referral may be because the psychological problems are not recognized by medical staff. Lack of responsiveness in the New Zealand health services to Asian patients' needs is another problem.

### **2.3.7. Available mental health resources for Chinese people**

Although Chinese are a vulnerable group and likely to be under stress in New Zealand communities, several studies have shown that Asians in general are health service under-users, especially for mental health issues (Ministry of Health, 2009a, 2010), and this is particularly serious for Chinese people. In addition to the shame issues among Chinese, lack of supportive resources for Chinese people nationally is the big obstacle in meeting Chinese people's mental health needs in New Zealand. For example, a study with health providers showed that most respondents reported dissatisfactions about the available resources in meeting their migrant patients' health needs (Nicola North, et al., 2006).

#### **2.3.7.1. Existing health and mental health information in Chinese language**

Lack of information in appropriate languages is a big barrier in accessing health services for people whose first language is not English (DeSouza & Garrett, 2005; Nicola North, et al., 2006), and it is also the key problem for Chinese people in receiving appropriate medical care. Many of them are not aware of the existence of services, especially mental health services, and they do not know where and how to seek help (Asian Public Health Project Team, 2003; Parackal, et al., 2007). Even though some information has already been translated into the Chinese language, it is far from adequate, especially in the mental health area. A simple search was made of the Ministry of Health – Health Education Resources Website in January 2011 (Ministry of Health, 2006b), using the term of “Chinese”. The Chinese version of information resources appears, with the results listed by publication date (newest first) (Table 5). Only 21 items of information among a total 576 pieces of information are available in Chinese (3.65 per cent), and that information is most likely to have been published in the last 3 years. Within 20 different categories, 11 items are found on child health, 4 items are related to information on immunisation, and 6 items relate to women's health. There is no Chinese version of information about mental health or the health of new migrants. In addition, the education website contains specific categories on Maori and Pacific people's health. Under the Maori Health category, 31 results are shown, and under the

Pacific Island People's Health's category, 65 results are shown. However, there is no specific category for Asian or Chinese health.

**Table 5: Health information in Chinese available from Ministry of Health – HealthEd Website**

Item	Title	Reference	Pub.Date	Categorise	Total
1	Keeping an Eye on Your Child's Hearing (B4 School Hearing Screening) trad Chinese	HE2290	1/06/2010	Child Health and Safety, Hearing	4
2	Referral for a Full Assessment (B4 School Hearing Screening) trad Chinese	HE2291	1/06/2010		
3	Keeping an Eye on Your Child's Hearing (B4 School Hearing Screening) simplified Chinese	HE2292	1/06/2010		
4	Referral for a Full Assessment (B4 School Hearing Screening) simplified Chinese	HE2293	1/06/2010		
5	Keeping an Eye on Your Child's Vision (B4 School Vision Screening) trad Chinese	HE2304	1/06/2010	Child Health and Safety	4
6	Referral for a Full Assessment (B4 School Vision Screening) trad Chinese	HE2305	1/06/2010		
7	Keeping an Eye on Your Child's Vision (B4 School Vision Screening) simplified Chinese	HE2306	1/06/2010		
8	Referral for a Full Assessment (B4 School Vision Screening) simplified Chinese	HE2307	1/06/2010		
9	BCG Vaccine: Information for Parents (Chinese)	HE2225	1/10/2009	Immunisation	4
10	BCG Vaccine: After care for Parents (Chinese )	HE2246	1/10/2009	Child Health and Safety	2
11	Cervical Cancer Vaccine (HPV; Chinese)	HE2037	1/12/2008		
12	One Thing You Can Protect Them From (HPV; Chinese)	HE2043	1/12/2008		
13	B4 School Check: Information for Parents and Guardians (Chinese Simplified)	HP4670	1/12/2008		
14	B4 School Check: Information for Parents and Guardians (Trad. Chinese)	HP4671	1/12/2008	Women's Health	6
15	BreastScreen Aotearoa (Chinese)	HE1839	1/08/2008		
16	Now that You've Had Your Mammogram (Chinese)	HE1844	1/08/2008	Child Health and Safety, Nutrition and physical activity	1
17	When You Are Recalled for Assessment (further tests) (Chinese)	HE1849	1/08/2008		
18	Information for Women under 45 Years of Age (Chinese)	HE1854	1/08/2008		
19	HIV Testing in Pregnancy (Traditional Chinese)	HE1931	1/06/2008		
20	HIV Testing in Pregnancy (Simplified Chinese)	HE1932	1/06/2008		
21	Breastfeeding Your Baby (Chinese)	HE2102	1/01/2001		

In New Zealand, information is available from a wide range of sources, including non-government sources, and varies around the country. Nationally, for instance, a Chinese version of *A Guide for People with Cancer* is available from the Cancer Society (Cancer Society of New Zealand, 2008). In the case of mental health, *You Are Not Alone* (Feeling Angry, Feeling Lonely, Feeling Sad, and Feeling Stressed) – is a series of four pamphlets in Chinese, available from the Mental Health Foundation. In the Auckland region, information in Chinese is more likely to be available than in other regions. Moreover, a Chinese community health support service is one of the places that can offer health-related information. For example, *Bo Ai She* in Auckland is one of the supportive Chinese organisations, which offers mental health information and help to patients and their families in dealing with their mental illness.

### 2.3.7.2. Availability of Chinese health providers

A study from America indicated that the awareness of the cultural differences among clients by health providers are essential for providing successful services to clients from culturally diverse population (Sue, Sue, & Sue, 1990). Health professionals' beliefs and actions could affect the efficiency of communication between health providers and their patients. Therefore, health providers who come from the same cultural background, and who can speak the same language have an important role in providing quality health services for different ethnic groups. It could make the conversation between health providers and patients much easier and reduce any misunderstanding. As a patient, she/he could feel more emotional support from the health providers as well. Under this circumstance, Chinese health providers are the preferred group offering quality of health services for Chinese people, especially as they understand the background of Chinese (the basic beliefs and attitudes), and understand of Chinese people's migration experiences and the implications for mental health needs.

#### Chinese health providers in western health services

Chinese health providers who work in the mainstream western medical field are the bridge between the New Zealand health care system and the Chinese culture because they are not only have the knowledge of western health care, but also have an understanding of Chinese people.

According to the Medical Workforce Report (Medical Council of New Zealand, 2009), only 5.4 per cent of health providers identified themselves as of Chinese ethnicity, and Europeans remain dominant in the medical workforce (Table 6). Small proportions of health

**Table 6: Ethnicity and average age of the medical workforce**

Ethnicity	2009	2008	2007	2006	2005	2004	Average age	
							Females	Males
New Zealand Māori	3.0	3.1	2.7	2.5	2.6	2.6	38	42
Pacific Island	1.4	1.8	1.6	1.6	1.5	1.3	38	43
Chinese	5.4	5.9	5.7	5.2	5.4	5.8	34	40
Indian	5.7	5.3	5.2	5.2	5.1	5.4	40	43
Other non-European	10.5	11.3	11.1	10.8	10.8	8.7	41	45
Other European	18.2	15.8	15.3	17.3	15.4	16.2	41	45
NZ European / Pakeha	53.9	55.3	56.9	55.9	57.5	58.4	43	47
Not answered	1.7	1.2	1.4	1.3	1.5	1.5	37	47
Refused	0.1	0.2	0.4	0.2	0.2	0.2	45	55
Total <sup>1</sup>	100	100	100	100	100	100	41	47

<sup>1</sup> Individual categories may not add up to total due to rounding.

Source: Medical Workforce Report (Medical Council of New Zealand, 2009)

providers are also Maori (3.0 per cent) and Pacific (1.4 per cent). Therefore, Chinese, Maori and Pacific and Pacific are the groups which have been underrepresented compared to their proportion of the the population in New Zealand. There are small differences in the annual percentages of Chinese health Chinese health providers, but the overall trend has not changed much between 2004 and 2009, from 5.2 2009, from 5.2 (lowest) in 2006 to 5.9 (highest) in 2008 (

Table 6). The GP is often the first contact for people to access primary health care in New Zealand, according to the *Mental Health Service use in New Zealand* (Ministry of Health, 2010), with general practitioners the most common source of referrals to mental health services in 2007/08. However, only small proportion Chinese doctors work in primary care. Among all Chinese doctors, only 29 per cent were GPs (

Table 7). Furthermore, Chinese providers had the youngest age structure

**Table 7: Proportion of ethnic groups by work role at main work sites**

Ethnicity	No answer	Other	GP	HO	MO	PC	R	S	Total <sup>1</sup>
New Zealand Māori	2	4	30	19	4	1	18	23	100
Pacific Island	2	2	30	13	3	3	23	24	100
Chinese	1	1	29	18	2	0	28	21	100
Indian	1	1	26	14	6	0	26	26	100
Other non-European	1	1	29	15	6	1	24	22	100
Other European	1	2	32	8	7	1	16	33	100
NZ European / Pakeha	1	3	33	6	4	2	10	41	100

<sup>1</sup> Individual categories may not add up to total due to rounding.

GP: general practitioner; HO: house officer; MO: medical officer; PC: primary care other than GP; R: registrar; S: specialist

Source: Medical Workforce Report (Medical Council of New Zealand, 2009)

for both female (34 years old) and male (40 years old), compared with Maori (38 years old, 42 years old), 42 years old), Pacific (38 years old, 43 years old) and New Zealand European (43 years old, 47 years old). 47 years old). The highest percentage (28 per cent) of Chinese doctors is in the registrar category (

Table 7), implying that these would more likely become specialists in a few years. The reasons why Chinese students are more likely to be attracted by specialist training is unclear, but may relate to Chinese people's cultural respect for specialists.

### **Chinese health providers from Traditional Chinese Medicine**

Traditional Chinese Medicine (TCM) has been successfully used for thousands of years in China to help its people recover from a wide range of illnesses. It has its unique system to diagnose and cure illness, which is fundamentally different from scientific-based western medicine. For instance, the understanding of the human body is based on the holistic level of a person, and the treatment of illness is based primarily on the diagnosis and differentiation of syndromes. In TCM, several treatments can be used in improving people's health conditions, particularly acupuncture, Chinese herbs, moxibustion (the warming of



acupuncture points using the herb *Artemisia*), dietary or lifestyle advice, gentle exercise (tai chi) or breathing (qi gong) techniques. Each treatment can be practised alone or in combinations (New Zealand Register of Acupuncturists, 2011).

The New Zealand Register of Acupuncturists (NZRA) is the longest established and largest democratic and professional institution for the training of practitioners of acupuncture and Chinese Herbal Medicine in New Zealand. To become a member, practitioners have to meet the highest standards of education, professional conduct and practice. Moreover, all members of NZRA are bound by the Rules and Ethical Guidelines of the organisation and are required to complete on-going professional education in order to maintain their Annual Practising Certificate. According to its record, totally 401 members are registered, and it includes 177 (44.14 per cent) practitioners of Chinese ethnicity (Haiselden, 2011).

In New Zealand, a few studies have explored the utilisation of Traditional Chinese Medicine, and discovered that, despite the importance of western medicine, it is commonly used by Chinese people, particularly acupuncture, combined herb formula and massage. Chan's (2004) case studies highlighted that people's previous experiences, beliefs and culture had a significant impact on the individual's help seeking, and the decision-making during illnesses. According to the study, with the people who used Chinese Medicine as a complementary and alternative medicine (CAM), most of them had a positive experience. They got benefits for both physical and for mental health problems. Another survey found that acupuncture is the most common CAM acceptable to GPs in New Zealand, while the Traditional Chinese Medicine was rarely suggested by them (Poynton, Dowell, Dew, & Egan, 2006). However, following the recognition of the effectiveness of Chinese herbs, this situation might change, and in the UK, the use of herbal medicines becomes more and more popular among the general public (Barnes, 2006).

One more study (Nicola North, 2008) explored 14 self-employed migrant Chinese and Indian doctors who are practising CAM in New Zealand. The study demonstrated that in New Zealand, Chinese medicine health providers experience many difficulties in providing their services. They tend to have a lower social status than they would in China, as they do not have the right to make diagnosis and referrals, as well as being unable to practise in hospitals. Therefore, they tend to be isolated in the health services. This study also indicated that except ACC funded acupuncture, Chinese medicine as a CAM, is less likely to get financial supports for their services, therefore, the high cost in the service is considered as a major obstacle in preventing people from accessing it. The providers also expressed the need for establishing

standards to ensure the quality of service, and remove poorly trained practitioners. Moreover, western clients were perceived as having very little understanding about the underlying theories of non-western medicine; therefore, more than half respondents prepared translated information in English to meet their clients' needs. Many of them also worked flexible hours to suit their clients' requirements.

### **2.3.7.3. Supportive mental health services for Chinese people within New Zealand**

The community's participation and its cooperation with other organisations and health research projects have an important role in meeting different ethnic groups' mental health needs, and the importance of this has been emphasised by the New Zealand Primary Health Care Strategy (Ministry of Health, 2001). Furthermore, even though most Chinese community-based services experience a resource shortage, good health outcomes have been identified for Chinese in improving and maintaining their wellness (Asian Public Health Project Team, 2003). In addition, following the dramatic economic, socio-political and cultural changes in China, people's understanding of mental illness is gradually changing. In China, patients are becoming more knowledgeable than before, and they are willing to take a more active role in "managing" their health (IBM Institute for Business Value, n.d; Nash, Wong, & Trlin, 2006). The purpose of developing more culturally-sensitive services is to ensure Chinese mental health patients and their families who are in the community get good quality of care.

However, quality can be defined in different ways. As Funk et al. (2009, p. 415) noted: for the patient, quality can be "reduction in symptoms, able to carry on with 'normal' life and being treated with dignity and with full respect of his/her rights to autonomy and independent decision-making". For their families, quality means "being provided with support to help cope with some of the emotional consequences of having an ill family member and being provided with the information and skills to actively assist a family member's integration into the community". For the service providers, quality can mean "ensuring that patients receive the best treatment and care available". For a policy-maker, "quality can be seen as the key to improving the mental health of the population, ensuring value for money expended and accountability". Regarding these varying perspectives, Chinese initiatives in New Zealand such as Bo Ai She society, Kai Xin Xing Dong programme and the Centre for Asian and Migrant Health Research are effective tools in meeting the different requirements. They have already helped many Chinese mental health

patients and their families to overcome cultural barriers and fight against stigma, and assisted them to get access to mainstream health services. They have also made efforts to compile specific health information for Chinese people and managed some important publications.

**Bo Ai She** (2008) is a volunteer Chinese mental health peer support organisation based in Auckland. ‘Bo’ means universal and also a personal effort, ‘Ai’ is love, and ‘She’ refers to community and home. It was first established in 2001, with the belief that the WRAP (Wellness Recovery Action Planning) programme could provide a better way to meet the needs of Chinese people for mental health services. Later, in 2003, it was restructured and registered as an incorporated society. Currently, it has 90 service user members at four Auckland locations (North Shore, Panmure, Howick and Mount Roskill) and involves physical exercise, recovery work, and educational sessions. The organisation is operated by a committee with two mental health professionals (from the Chinese Mental Health Consultation Services) and five members who are elected from all members within the organisation.

Bo Ai She has become a place where Chinese service users can express their concerns and share their personal experiences. Service users may also meet and provide additional support to each other outside the programme. Their goal is helping people build up their own self-motivation and overcome self-stigma, instead of ‘fixing’ them. This service also helps overcome workforce shortage, addresses isolation and stigma experienced by Chinese service users, and improves and maintains their wellness.

**Kai Xin Xing Dong (KXXD)** (nd) slogan *“I have a caring and loving heart towards you and I hope you have a caring and loving heart towards me too. – Reducing stigma and discrimination associated with mental illness.”*

This information is found on the Mental Health Foundation’s website. ‘Kai’ means open. ‘Xin’ means heart. Put ‘Kai Xin’ together means ‘you get happy’. ‘Xing Dong’ means action. The overall meaning of ‘Kai Xin Xing Dong’ is ‘happy action, with an open heart’. The project is called “Kai Xin Xing Dong” because it is hoped that everyone can have a happy and healthy life, and an open heart to treat people with respect.

The media campaign of Like Minds, Like Mine project identified the needs in a more culturally meaningful way to bring the message into Chinese communities in 2005, and KXXD was established in 2006. The project focused on gathering information and providing resources to support Chinese communities to understand mental illness, and to encourage Chinese people who experience mental illness to seek help and support through mental health

services and community networks. The project is funded by the Ministry of Health and guided by the Kai Xin Xing Dong Advisory Group. The services include newspaper advertising campaigns, communications, resource development, research and education and training in the Auckland Region. It published a significant literature review: *Chinese Attitudes Toward Mental Health* (Kai Xin Xing Dong Advisory Group, Like Minds, & Mental Health Foundation of New Zealand, 2008).

***Centre for Asian and Migrant Health Research*** (2008) was formed in 2003 from the National Institute for Public Health and Mental Health Research in the Auckland University of Technology (AUT). It was formerly the *Asian Pacific Centre for Community Health and Research*, and researched migrant and Asian health issues for more than 10 years. Today, this centre is run by an Advisory Group composed of people from Asian, migrant and refugee communities.

The aim of the Centre is to give a research based understanding of Asian and migrant populations' health and then improve access to healthcare and promote good health among the Asian and migrant populations in New Zealand. It also co-operates with other academic institutions, government, non-government organisations, and Asian and migrant communities. All information and research findings are widely disseminated to inform policy development, health care providers, health professionals, students, policymakers and the wider community. The Centre is also committed to contributing to the development of the Asian and migrant health research workforce. A key focus of the Centre is its commitment to work with Asian and migrant communities through support of those communities.

*Important current projects on mental health:*

1. Migrant fathers' experiences of fathering in a new country: Implications for health and social service providers
2. The experience of traumatic birth and PTSD after childbirth: Perspectives of ethnic women
3. Perinatal depression screening/assessment instruments and migrant women
4. Chinese university students' coping and wellbeing
5. International Student Pilot Study
6. The adjustment to parenting for ethnic women (becoming a mother in a new country)
7. Accident Compensation Corporation Report
8. An Asian Perspective: A Background Paper

There have been several important journal articles, such as *Depression in Older Chinese Migrants to Auckland* (Abbott, et al., 2003), *Recent Chinese Migrants Health Adjustment to Life in New Zealand and Primary Health Care Utilisation* (Abbott, et al., 2000), and *Chinese Migrants Mental Health and Adjustment to Life in New Zealand* (Abbott, et al., 1999).

**Asian Health Support Services (AHSS)** (WDHB, 2008a) is one of the Waitemata District Health Board's Clinical Support Services, established to support and deliver more responsive, accessible, and culturally appropriate services to Asian migrant and refugee communities. To support their clients and practitioners, it collaborates with communities and other agencies, offers access to resources and interpreter services, and provides cultural training for staff to improve cultural awareness, therefore to achieve better health outcomes, improve communication, reduce inequalities and remove cultural barriers. Under one roof, Chinese people are supported to get the information about the New Zealand health system, cultural support, emotional support as well as language support. The translated information in Chinese language can be found from its website.

Asian Mental Health Client Coordination and Support Service (WDHB, 2008b) is the particular service to support the clients with mental health issues. It offers community and hospital based support to people with mental health problems to promote Asian mental health and wellbeing, maintain and support the rights of Asian mental health consumers, provide quality services, provide mental health resources and creates a stigma free environment. The services include the Asian mental health clinical cultural advisors, an Asian mental health cultural support coordinator, and Asian mental health interpreters.

**Help lines** can offer free, confidential and professional services for Chinese people through the telephone and websites. Sometimes, Chinese only speakers are afraid to pick up the phone, but in this case, they do not need to worry about their English, because they can talk to the staff in their own language and those professionals are ready to help them.

**Chinese Lifeline** (Chinese Lifeline, nd) (09 522 2088 or 0800 888 880) is the New Zealand national telephone support service for Chinese speakers at the Centre for Asian and Migrant Health Research under the umbrella of Lifeline Auckland. It has been supporting the Chinese community through the telephone and face to face counselling services for more than 15 years. The information also can be found from its website, including why you would phone a counselling service, who talks with you and what good it is; their volunteers; their sponsors; and how to contact them.

*Asian Hot Line of Problem Gambling Foundation* (Asian Hot Line of Problem Gambling Foundation, nd) (0800 862 342) which offers free services for the gambler, their family and others who are affected by problem gambling. It includes a National Office in Auckland, and three other locations in Hamilton, Wellington and Christchurch.

## 2.4. Overview of mental health services in Christchurch

### 2.4.1. Canterbury District Health Board (CDHB)

Established in 2000, the CDHB is responsible for funding, planning and the direct or indirect provision of health services, especially primary and secondary care services in its region, and Christchurch comes under its authority (CDHB, 2007).

The information about specialised mental health services in Christchurch was found from the CDHB's website, including emergency services, hospital-based specialist care, and community-based mental health services (see Table 8). The Psychiatric Emergency Service

**Table 8: Mental health services under CDHB (CDHB, 2007)**

Emergency Services		
Hospital-based mental health services	Hillmorton Hospital	<ul style="list-style-type: none"> <li>• Acute Psychiatric Inpatient Service</li> <li>• Alcohol &amp; Drug Detox Unit</li> <li>• Psychiatric Service for Adults with an Intellectual Disability (PSAID)</li> <li>• Rehabilitation Service</li> <li>• Regional Forensic Psychiatric Services</li> <li>• Te Korowai Atawhai (Maori Mental Health)</li> <li>• Work Assessment &amp; Rehabilitation Services</li> <li>• Youth Speciality Services</li> </ul>
	Princess Margaret Hospital	<ul style="list-style-type: none"> <li>• Child, Adolescent and Family Mental Health</li> <li>• Eating Disorders Service</li> <li>• Mothers &amp; Babies Unit</li> <li>• Child &amp; Family Inpatient Unit and Day Programme, which treats children in the context of their family and has some accommodation for parents to stay at stages of their child's care</li> <li>• Youth Inpatient Unit which treats young people with mental health difficulties.</li> <li>• Youth Day Programme which provides psychiatric interventions for young people between the ages of 13 and 18 years old age.</li> <li>• Eating Disorders Service, Mothers &amp; Babies Unit, Child &amp; Family Inpatient Unit and Youth Inpatient Unit provide services to the South Island region.</li> <li>• Intensive Case Management Team provides systems of care and wraparound services for young people under the care of Child, Youth &amp; Family who have mental health difficulties.</li> <li>• Psychiatric Needs Assessments</li> <li>• Mental Health Services' management and administration</li> </ul>
Community-based Services		<ul style="list-style-type: none"> <li>• Adult Community Psychiatric Services</li> <li>• Alcohol and Drug Services</li> <li>• Anxiety Disorders Unit</li> <li>• Child, Adolescent and Family Mental Health</li> <li>• Clinical Research Team</li> <li>• Community Intensive Care Team</li> <li>• Psychiatric Consultation Service</li> <li>• Rehabilitation</li> <li>• Totara House - Early Intervention in Psychosis Service</li> </ul>

Phone line provides 24-hour psychiatric support to the patients, their family members, friends, as well as GPs or community agencies in an urgent situation. Hillmorton Hospital

and the Princess Margaret Hospital offer specialised mental health services, through inpatient care, day-patient care to outpatient care, and through acute intensive support to rehabilitation services. Community-based mental health services play a major role in providing mental health services. According to the Ministry of Health (2009b), about 90 per cent of service users only access community services. Therefore, people with mental health issues might get strong support from these services in Christchurch; for example, Adult Community Psychiatric Services offer non-residential assessment, treatment and support services to adults aged 18 to 65 years living in the community (Canterbury DHB Adult Community Mental Health Services, 2011). Furthermore, the Clinical Research Team develops knowledge about mental disorders by clinical research, and the dissemination of local and international research findings into primary health care, hospital based medical care and mental health services in Canterbury. In addition to the CDHB's own services, many contracted, community-based non-government organisations (NGOs) provide support services to people with mental illnesses.

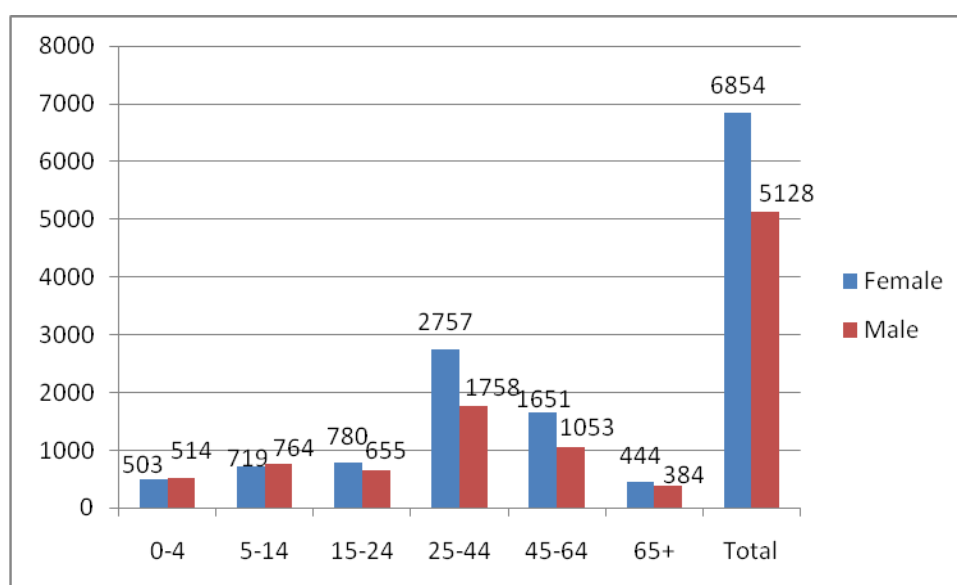
Some health professionals have noticed the increasing need for cultural understanding in the mental health field in Christchurch. At the Clinical Meeting of Specialist Mental Health Service CDHB, Dr Smith and Dr Dean presented "Culture in Christchurch: Cultural Considerations in Mental Health" (2010). They indicated that culture might influence mental illness by defining the normal from the abnormal, implicating domains of aetiological factors, and influencing the clinical presentation. An example was given: the presentation of depression among Chinese people is characterised as boredom, inner pressure, pain, dizziness, or fatigue. Indeed, culture might affect assessment during the treatment, and five 'R's are suggested to increase reliability and validity in interviewing: Recognise common presentation, Rapport, Reframe, Recheck, and Re-validate. They also pointed out that using an interpreter seems as a simple solution but the concern is that the subjective quality of the interpretation cannot be easily taken away, and the emotional expression might be lost in the intercultural setting, especially in the mental health field.

#### **2.4.2. Primary Health Organisations in Christchurch**

**Partnership Health Canterbury (PHC) (2010a):** is the largest primary health organisation (PHO) in New Zealand, and was established in 2004. It is funded (via the Canterbury District Health Board (CDHB)) to provide essential primary health care services to those people who are enrolled with the PHO. It works with Pegasus Health, GPs and other community-based health services to deliver primary health care to its enrolled populations,

which are over 365,000 people in and around Christchurch. Among these services, general practice has a key position in the delivery of primary mental health services because in most cases, general practice is the first point of contact for people accessing the health system, especially for people with mental health issues.

There are more than 376,000 people enrolled with Partnership Health Canterbury, including over 25,000 Maori, 22,000 Asians and 9,000 Pacific Islanders. According to PHC, the total enrolled Chinese population was 11,928, including 6,854 females and 5,128 males (Ethnic Liaison Manager PHC personal communication, 2011). More than 4,500 Chinese people were aged between 25 and 44, and this is about 37.85 per cent of the overall enrolled Chinese population. The Chinese aged over 65 were only around 800 (see Figure 12). Furthermore, PHC works in conjunction with more than 100 general practices to improve the health and well-being of the enrolled population. Among these general practice services, Doctors on Riccarton has the highest enrolled Chinese population which was about 4,000 Chinese patients, and the second largest practice with Chinese clients is Grahams Road Surgery, which has more than 1,500 Chinese patients enrolled. Those two services included about half of the Chinese population enrolled with PHC (Ethnic Liaison Manager PHC personal communication, 2011).



**Figure 12: Enrolled Chinese patients with PHO by gender and age**

In *the Asian Health Action Plan 01 July 2010 to 30 June 2011* (PHC, 2010b), it was clearly stated that PHC would work towards improving health outcomes for Asian people by accessing culturally linguistically appropriate services, increasing the number of Asian people enrolled with general practice, increasing workforce capacity and capability of



providers, and designing and targeting health promotion specifically for Asian people. Thirty two thousand dollars were allocated to assist the implementation, and under *the Strategic Goal Four*, the community education around mental health issues is on the list. PHC will be working with community groups, creating awareness amongst general practice teams of the cultural issues surrounding mental health, to increase the number of Asian people accessing mental health services. However, unlike Auckland PHOs, PHC received no specific funding from their DHB for Asian migrants' mental health care (Ethnic Liaison Manager PHC personal communication, 2011). Furthermore, PHC is developing available information in different Asian languages, and by now, on PHC's website, under the Refugee and Migrant category, a few pieces of translated information are available for people to look up or download, including reference to diabetes, heart disease, influenza, and cancer. However, no mental health related information is found yet. PHC also works in partnership with the CDHB and other primary care organisations, with independent practitioner associations (IPAs), as well as NGOs.

In the last three years, three pieces of research were published related to Asian health in Christchurch, including *Healthcare Needs of Asian People in the Wider Christchurch Area* (Reid, Tam, Tam, Ahkuoi, & Hou, 2008), *Primary Health Care Issues Amongst Asian People in Christchurch* (Reid, 2010), *Nutritional Needs Assessment of East Asians Living in Christchurch* (Zhang & Reid, 2010). The studies pointed out that in Christchurch, the fact of the high level of poor English skills among Chinese people might indicate the increasing number of older people coming to New Zealand under the family category. Smoking and gambling were the two major concerns among the Chinese respondents. Moreover, only 2 per cent of Chinese people reported using mental health services, and 5 per cent accessed private psychiatrists. The participants were more likely to report a neutral or negative satisfaction about the health service. Only 31 per cent were satisfied with the interpreter service, reported that it takes time to find a suitable interpreter. Nearly 50 per cent of participants stated that they would go back to their home country for their medical treatment.

**Christchurch PHO (CPHO)** is another primary health organisation in Christchurch, and it offers primary health care to nearly 31,555 people. Among the programmes of the PHO, mental health-related services are available for the public, including brief intervention co-ordination (BIC), extended GP consultation, GP Liaison, and YBIC Youth BIC. The program of *Tomorrow is a new day – healthy minds* is running by CPHO to help people regain mental strength. Through the link of CPHO, health professionals can get access to a

range of resources, including Waitemata District Health Board, and overseas sites which have translated information in health (same as PHC).

- [www.caldreasuresources.org.nz](http://www.caldreasuresources.org.nz).
- [www.nlm.nih.gov/medlineplus/languages/languages.html](http://www.nlm.nih.gov/medlineplus/languages/languages.html)
- [www.healthtranslations.vic.gov.au/](http://www.healthtranslations.vic.gov.au/)
- [www.mhcs.health.nsw.gov.au/](http://www.mhcs.health.nsw.gov.au/)

According to its record, a total of 1,265 Chinese people were enrolled with CPHO (Table 9) (CPHO personal communication, 2011). The CPHO funds education sessions run by doctors at Burnside Medical Centre for new Asian migrants.

**Table 9: Enrolled Chinese population with Christchurch PHO**

Service	Chinese population
Burnside Medical Centre	38
Casebrook Surgery	13
Moorhouse Medical Centre	162
Riccarton Clinic	679
University Health Centre	373
Total	1265

### **2.4.3. Mental Health Education and Resource Centre (MHERC)**

The Canterbury Mental Health Education and Resource Centre was established as a charitable trust in 1993 to support mental illness patients, their families, non-government organisations, and the community (MHERC, 2011). It offers support, networking, education and sharing material resources to promote a wider community. The free information about mental health, community and hospital services, networks, support groups, training and education are supplied from its services. A free on-site mental health library is offered for public with online access, and a free rural postal service is also available for local people. For example, a drop-in service for Asian women offered by Womens Centre was found from its website. The clients might be assisted to get extra support from other organisations, including accommodation or employment assistance. The mental health related education and workforce development are proposed for both professional people (health providers and students who are working and studying in the mental health field) and people who have an interest of mental health for public.

#### **2.4.4. Christchurch Women's Centre (CWC)**

This is a community organisation, which was established in 1986 to offer a safe, supportive, affirming, environment to women (CWC, nd). An Asian women's drop-in service is set up on Fridays from 10am – 2pm to provide information, support and referrals on all women's issues. A Chinese woman speaker can come in to the service or they can ring up and talk to the Chinese support worker. A 'listening ear' is offered, and the client is supported to make their own decision or contact other agencies. Although the Chinese speaking volunteer is not a trained counsellor or social worker, she has trained in talking to women and she is supervised and supported by the experienced staff (Centre Co-ordinator CWC personal communication, 2011). The Centre also runs seminars on cervical screening and breast screening, and a translator is provided for Chinese people. An information sheet on abortion/contraception is produced for Chinese women, and it is available from various agencies. A folder of information which is relevant to Chinese women also can be read or copied in there, at no cost. At the moment, the number of Chinese women who make use of the services is small, and the common problems for the Chinese women are characterised as employment issues, immigration issues and relationship problems (Centre Co-ordinator CWC personal communication, 2011).

#### **2.4.5. The Problem Gambling Foundation (PGF) Christchurch Branch**

PGF has a branch in Christchurch (Problem Gambling Foundation of New Zealand, 2011). It is a national non-profit organisation predominantly funded by the Ministry of Health with funds received from the gambling levy. Its website contains particular Chinese language-based information, and the Asian Family Service provide free and confidential professional counseling and advice in Cantonese and Mandarin for Chinese people. Moreover, the counseling services are not only by phone, but also for face-to-face services. Its services also are advertised in the local Christchurch Chinese newspapers.

### **2.5. Conclusion**

Via the literature review, the key mental health and service use issues for Chinese people in New Zealand have been identified. On the surface, Chinese people are a healthy and well-adjusted ethnic minority group, but underneath the mask, Chinese people are a vulnerable group, and they are experiencing many difficulties during the resettlement and have many risk factors for mental health. Currently, health, especially mental health, issues of

Chinese people have received very little public and professional attention in New Zealand. Lack of population-based prevalence information of mental health becomes a big obstacle in identifying existing problems and improving the quality of the mental health services for Chinese people. Moreover, the mixture of health issues among the Asian population in national studies might underestimate some important health issues. Therefore, the mental health issues of Chinese people are overlooked.

The fact that Chinese people are under-users of health services has been identified by a number of studies, and lack of supportive resources in Chinese in the mainstream mental health services is one of the big issues. The Auckland region seems to have a much stronger supportive environment than the other locations, with more community-supported mental health services available for Chinese people. In addition, mental illness is not very acceptable in Chinese culture, and because of 'face' and shame issues, people tend to hide their problems. Together with lack of mental health literacy and awareness, mental illness among the Chinese population is more likely to be under-recognized, un-treated, and under-reported.

In Christchurch, Chinese people's mental health issues have not been given much attention. Even though many good services are available to support people with mental health issues in general, without good English, they might not be able to use them. Very few resources have been developed for Chinese people in the mental health services, especially from the CDHB services of specialist mental health care and the supported community-based mental health care. Therefore, lack of culturally appropriate services might be a concern for low utilisation of mental health services, and in fact, the number of Chinese people who access mental health services is very low.

With the large growth in the number of Chinese in Christchurch, there has been a corresponding increase in the demand for research to gain more information from health providers who offer mental health services to Chinese people. This would improve our understanding of the needs and adjustments of different ethnic minority groups. Current studies are mostly based on the clients' view of Chinese people's mental health issues, and little is known about how mental health providers perceive and support their Chinese clients because there is virtually no research that has investigated health providers' perspectives on Chinese people's mental health issues in Christchurch. Therefore, this priority area for research is the focus of this study. Being aware of the health providers' perspective might encourage changes to improve the quality of mental health services for local Chinese people and even throughout New Zealand.

## Chapter 3: Methods

This chapter describes the methods used in this research. The primary data collection consists of two main parts. The first part introduces the methods of conducting the literature review. The second part demonstrates the descriptive qualitative research method which was used to investigate the western and Chinese health providers' perspectives on Chinese people's mental health and service use issues.

### 3.1. The literature review

The literature review was carried out using the Internet, library databases and bibliographies of literature obtained from original searches. This review was focused on recent publications in the health area, especially mental health. These were sought through New Zealand International/National Bibliographic database, Index New Zealand – journal articles, Ministry of Health, Statistics New Zealand, Pub Med, and PsycInfo. A Google search gathered related information. The terms *Chinese*, *Asian* and *migrants/immigrants*, and *mental health/disorder/ illness* were used to identify the relevant articles.

The socio-demographic information was mainly based on the *New Zealand 2006 census* from the Statistics New Zealand Website (Statistics New Zealand, 2006) which provided details of the social and demographic background of Chinese ethnic groups. Due to the significant proportion of migrants among Chinese population, the publications from the Department of Labour gave information on migrant trends and changes. It also monitored how well migrants fit into the new environment and whether those migrants could meet the needs of New Zealand labour market. Moreover, the *Migrants Report* from the Christchurch City Council (Thorpe et al., 2007) offered detailed information about Chinese in Christchurch city.

Nationally, the Ministry of Health was the important resource for official documents on health research and health information. The Auckland University Centre for Asian and Migrant Health Research specifically focused its research on public health issues in order to improve access to healthcare and promote good health among the Asian and migrant populations in New Zealand. The information on traditional Chinese medicine in New Zealand was found from the website of New Zealand Register of Acupuncturists (NZRA).

Information on the scope of local mental health services was drawn largely from the websites of provider organisations. In Christchurch, the Canterbury District Health Board (CDHB) and the Primary Health Organisations (PHOs) were valuable sites containing local information. Under the CDHB, Hillmorton Hospital, as a specialist mental health treatment centre in Christchurch, provides useful information. Partnership Health Canterbury and other PHOs, responsible for primary mental health care, also provided information. Non-government health organisations, for instance, the Mental Health Foundation and Problem Gambling Foundation also provide helpful information about mental health services in the city. Moreover, these sites coordinate together in offering mental health information to the public. For example, PHC's website had the link to partner organisations, including the Mental Health Foundation, Mental Health Education and Resource Centre (MHERC), and other important resources.

This research followed a thorough and systematic process which provided background information about Chinese people and services use issues in New Zealand. The information was initially collected through the websites of individual organisations, and the terms 'mental health' and 'Chinese' were used to get the particular information for Chinese people. Moreover, further information had been added when the researcher identified available mental health services for Chinese people through the interviews.

### **3.2. Descriptive qualitative research**

Qualitative research is "a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live" (Holloway, 1997, p. 1). Therefore, it helps people to understand the social reality of individuals, groups and cultures through exploring behaviour, perspectives and experiences of people. For these reasons, qualitative research is used by researchers in health, education, social work, and other fields, such as sociology, anthropology, psychology, business and organisational studies.

As descriptive qualitative studies have as their goal "a comprehensive summary of events" (Sandelowski, 2000, p. 334), this method was chosen for interviewing health providers to describe their experiences and understanding of Chinese people's mental health and service use issues. The literature review (chapter 2) revealed that although Chinese people are under-users of mental health services, in reality, many of them do suffer from mental health problems. In Christchurch, at present, the fact that little attention is on Chinese

people's mental health issues might be because only a small number of Chinese patients present in clinical settings. Hence, by understanding health providers' perceptions of Chinese people's mental health and service use issues, it should be possible to identify further supportive actions and helpful improvements in the services.

### **3.2.1. Research question**

The overall question is: how do health providers perceive and support mental health needs of Chinese patients in Christchurch?

### **3.2.2. Objectives**

- To explore health providers' perspectives of key issues affecting the mental health of Chinese patients and their provision of treatment support;
- To reveal the barriers for health providers in offering mental health services to Chinese patients, and how they try to solve these problems;
- To identify what supports providers give to Chinese patients who use their services;
- To provide recommendations for improvement of services.

### **3.2.3. Ethical approval**

This study was submitted to the University of Canterbury Human Ethics Committee for review. The proposal illustrated the purpose of the study, and the processes of data collection and data analysis. The information sheet, consent form, and interview guide were also reviewed to ensure the protection of participants. Then, it was approved on 8 November 2010 (Reference number: HEC 2010/155).

### **3.2.4. Participants**

Health providers who offer mental health care were sought for interview from a wide range of services, including primary health providers (GPs and nurses), secondary health providers (psychiatrists), and health providers from non-government organisations (social workers). **Eligibility:** Health providers, who have experience with Chinese clients' mental health issues, were recruited in the study. This included both Chinese health providers and western health providers, due to the fact that in the mainstream health services the majority of health providers are westerners, but the small proportion of Chinese providers because of the cultural familiarity was expected to have an important role in servicing Chinese people and meeting their health needs.

### 3.2.5. Sample selection

The potential interviewees were selected based on purposive sampling. It is a commonly used sampling strategy, in which participants are chosen by the researcher on preselected criteria relevant to a particular research question (Sandelowski, 1995). In this study, the participants were identified based on the overview of mental health services and the researcher's and supervisors' knowledge. Moreover, as part of the interview, the participants were asked to recommend other interviewees who were also suitable for this study.

The participants in this study reflected the background of the potential sources of care for Chinese patients. Providers could have a Chinese language/cultural background or not, or be trained in either the Chinese or western tradition (shown as Table 10). Quadrant A indicates health providers who were in the western medical settings, and had Chinese language and culture, for example, they might be a Chinese GP, a Chinese psychiatrist, a Chinese nurse, or a Chinese health provider from non-government organisation. Quadrant B shows health providers who had both Traditional Chinese Medicine's knowledge, and Chinese language and culture, for example a Chinese medicine practitioner. Quadrant C reflects health providers who were trained in the western medicine, and did not have Chinese language and cultural background, for example, they could be a western GP, a western psychiatrist, or a western counsellor.

**Table 10: Range of health providers**

		Western Medicine	Chinese Medicine
Chinese language & culture	Yes	A	B
	No	C	N/A

### 3.2.6. Recruitment

During late November 2010 to late January 2011, 13 potential interviewees were contacted by email, to which an information sheet was attached (Appendix 1) to introduce the study and invite them to participate. Of these, three were contacted on several occasions; one did not respond, and two declined to be part of the study due to being exceptionally busy around Christmas and New Year. In addition, a fourth potential interviewee was contacted



and agreed to be interviewed but, after the initial contact, the researcher decided that he was not suitable for the study due to his little experience of Chinese people's mental health problems. Fortunately, another health provider was recommended by him, and was interviewed. In the end, nine participants were recruited in the study.

#### *Demographic profiles of participants:*

##### *Gender*

There was an almost equal representation of males and females within the sample. Of the nine health professionals, four were male and five were female.

##### *Age*

A broad age range was present in the sample: three were aged between 30 – 40 years old, one was in the age group of 41 – 50 years old, two were 51 – 60 years old, and three were aged 61 – 70 years old.

##### *Ethnicity, cultural tradition, training and professional background*

Five health providers identified themselves as Chinese, two were British European, and two were European New Zealanders. Overall, the proportions of Chinese respondents are similar to the western health providers (the sum of British European, and New Zealander).

Moreover, eight health providers are trained and work in the mainstream medical fields. Among them, four are Chinese and four are westerners. One more Chinese health provider trained in traditional Chinese medicine in China, and works in Christchurch.

The participants were working in different roles in the health field, including general practice, psychiatry, social work, counselling, project leadership, health promotion, management roles, nutrition, nursing, and Chinese medicine. Moreover, some of the interviewees held more than one position at the same time. For example, a general practitioner also could be a manager in charge in the service. In addition, some of the professionals were from primary health care, some of them were from specialised mental health care, and some of them were from the non-government organisations.

### **3.2.7. Semi-structured interviews**

Semi-structured face-to-face interviews were carried out with nine health providers from late November 2010 to late January 2011. Most of the interviews were completed in 45 minutes to one hour. According to Britten (1995), semi-structured interviews are conducted on the basis of a loose structure consisting of open ended questions that define the area to be explored, from which the interviewer or interviewee may diverge in order to pursue an idea in more detail. Holloway (1997) indicated that semi-structured interviews have a specific

research agenda and are quite focused, but with informants describing the situation in their own words and in their own time. Although the researcher did not ask the questions in the same way of each participant, the participants were given opportunities to report their own thoughts and ideas. (1997) (1997) (1997) (1997) (1997)(1997)(1997) Therefore, the semi-structured interviews offer flexibility for the researcher to focus on different aspects of health providers' perspectives on Chinese people's mental health issues.

### ***Interview guide***

An interview guide (Appendix 2) was developed based on the research question and the issues identified from the literature review. Seven core topic areas were asked of the health providers, these included:

- Basic demographic information
- Overall perspectives on their Chinese clients
- Mental health problems of Chinese people
- Treatment supports
- Barriers to treatment
- Availability of information and service in Chinese
- Other issues (recommendations or other important issues not covered in the interview)

The interviews were carried out based on the interview guide, with modifications to suit the different providers' individual situations. For example, the question: 'How often do you see a Chinese client?' was excluded from the interview of a manager who does not see clients himself. Instead, the questions were more focused on his view of health promotion and management.

### ***Interview procedure***

Step 1: After the recruitment, a list of interview questions and a consent form (Appendix 3) were sent by email to the interviewee at least three days before the interview. Therefore, the interviewees could have time to consider these topics.

Step 2: The time and place of interviews were decided after the previous contact with interviewees, and based on when/where was convenient for the interviewees. In this study, seven interviews were carried out at interviewees' working offices, one was done at the interviewee's home, and another health provider was interviewed in a discussion room at a library.

Step 3: The consent form was signed and collected at the beginning of each interview. During the interviews, the interviewees were encouraged to develop their ideas further by

being asked probes for more information or clarification. For example, ‘Can you tell me more about that?’ or ‘what do you mean by...?’ Moreover, leading questions to the participants were avoided to ensure the researcher did not add her judgements into the interviews. The respondents were free to decline to answer any question in the interview or withdraw from the study at any time for any reason.

Step 4: Seven interviews were audio recorded, with consent from participants. This facilitated the interview by eliminating the interruption of constant note taking and allowing normal conventions of social interaction such as eye contact between interviewer and participants. For the two participants who did not agree to be taped, notes were taken during the interviews. The interviews were carried out in their preferred language, and the majority of the interviewees spoke in English, but some particular phrases were used in Chinese by Chinese speaking health professionals and later translated by the researcher. Only one interview, with the Chinese medicine practitioner, was mostly undertaken in Mandarin due to the complex background of Chinese medicine, and then translated by the researcher who, herself, is bilingual. She is a Chinese, has the understanding of Chinese culture and learnt Chinese medicine alongside western medical training, and also during her work time in a psychiatric hospital in China.

Step 5: Eight of the interviewees agreed on the consent form to answer follow up questions. After the initial interview, further questions were asked by email or phone to some of the participants to clarify their responses in the interview, or include more information about the topics.

Step 6: The interviews were transcribed by the researcher based on the tape, and then reorganised according to each question which was asked in the interview. To ensure the credibility of data collection in the study, the interview transcripts were sent to the participants to review, if they wished. Finally, eight of them received and reviewed the interview transcripts. By doing this, the accuracy of the information gained from the interviews was enhanced, and the participants were offered an opportunity to exclude or change any information they offered in the interviews, therefore, they could feel more comfortable. For example, Ella shortened one paragraph describing how her motherhood experience helped her understand Chinese young people to just one sentence: “Some experience also comes from my kiwi culture, such as my experience as a daughter and as a Mother.”

Step 7: During the process, the researcher met her supervisors regularly to discuss the content of each interview. After nine interviews, data collection ceased. At this time the completed interviews reflected the range of possible practitioners who might provide mental health services to Chinese people in Christchurch.

### **3.2.8. Data analysis**

After data collection, every interviewee's name was replaced by pseudonym to ensure confidentiality. Thematic analysis (Holloway, 1997) was used to summarise the perspectives of how health providers perceive and support their Chinese mental health patients. Thematic analysis is where the researcher identifies themes and patterns in interviews through listening to tapes and reading transcripts. A theme (Holloway, 1997) is a cluster of linked information conveying similar meanings and forming a unit. During the process of data analysis, the themes and sub-themes were identified through the close reading of interview transcripts.

At the beginning of the analysis, it was assisted by using qualitative research software NVivo 8 to manage, shape and make sense of unstructured information. Although the software could not analyse for the researcher, it provided an efficient tool to work through the interview transcripts, for example, retrieving or sorting data. Information which had a similar meaning was categorised under the themes/sub-themes: the coding process. In NVivo 8, the themes are stored in nodes, and the sub-themes can be stored in the branches, which are called tree nodes. With the aid of NVivo, the frame of themes and sub-themes was created. However, due to the interruption of the Canterbury earthquake, the researcher could not access the software which was installed on the computer in her student office. Therefore, the remaining analysis was completed manually by the researcher. Then, four key steps were used to identify the themes and sub-themes from the interviews.

In the first step: The transcripts were closely read, until the researcher was familiar with the information from the interviews.

In the second step: A frame of themes, subthemes, and their relationships (tree nodes) were created based on the overall information from the interview transcripts. After close reading of the transcripts, the researcher had an impression about the information from the interview transcripts. Based on the impression, she established some themes and sub-themes and their relationships. During the coding process, the relevant information, phrases or sentences which had a similar meaning were located under each theme or subtheme (Table 11). For example, the main theme of stressors and its related sub-themes were created in step

one. The sub-themes include language problems, social isolation, cultural barriers, employment issues and unfamiliar health system.

**Table 11: Themes and sub-themes established in data analysis step one**

Themes	Sub-themes	
<b>Stressors</b>	<b>Migration-related</b> Language obstacle Social isolation Cultural barriers Unemployment/under employment	<b>Health related</b> Unfamiliar health system
<b>High risk groups</b>	Chinese elders	
<b>Support resources</b>	<b>Support from main services</b>	<b>Others (TCM)</b> Resources from Auckland
<b>Barriers</b>	<b>Chinese people</b> Language barriers in health 'Face' and shame issues Lack of knowledge and awareness Complain about physical health problems	<b>Services</b> Cultural differences Lack of services

In the third step: A free coding process was used to develop the frame further, and therefore new themes and sub-themes could be created which are highlighted in blue in Table 12. This involved searching information with a similar meaning (sub-themes), and grouping

**Table 12: Themes and sub-themes established in step two**

Themes	Sub-themes	
<b>Mental health problems</b>	Stress, Addiction problems; Relationship problems; Anxiety; Eating disorder; Depression; Suicide; Psychosis	
<b>Stressors</b>	<b>Migration-related</b> Expectations from migration Language obstacle Social isolation Cultural barriers Unemployment/under employment	<b>Health related</b> Unfamiliar health system Personal health
<b>High risk groups</b>	Chinese elders; Chinese students; People in between; Isolated people; Unwell people from China	
<b>Support resources</b>	<b>Support from mainstream services</b> General support Specific support	<b>Others</b> Openness and flexibility (Chinese people & services) Support within a practice location Trustful therapeutic relationship Family Church Helpful experiences Financial factors Resources and help from Auckland
<b>Barriers</b>	<b>Chinese people</b> Language barriers in health services 'Face' and shame issues Lack of knowledge and awareness Complain about physical health problems	<b>Services</b> Lack of attention from policy maker and funding supports Existing model does not suit Cultural differences Lack of resources in Chinese TCM
<b>Coping and help-seeking</b>	Not seeking help Self-treating, or informal support Delay in seeking help Going back to China to be treated	
<b>Possible solutions</b>	Using of an interpreter Build up specific mental health resources Approaching Chinese people in an appropriate way Education: (Chinese people & health providers)	

them together. For example, the sub-themes of Chinese students, people in between, isolated people, unwell people from China, together with Chinese elders were grouped together under the high risk groups. If the new theme did not suit any category, then a new independent theme was created. For example, the information about Coping and help-seeking were created as a main theme in the findings.

In the fourth step: During the process of analysis, these themes and sub-themes were continually revised and reviewed, until no new theme or sub-theme could be identified or no further changes could be made. For example, the sub-theme of traditional Chinese medicine (TCM) (highlighted in red) was located in the support resources in the first step. Then, because more information appears about concerns and barriers about TCM in supporting Chinese people in the health services, the researcher decided to shift this sub-theme into the sub-theme of barriers to the services.

In the fifth step: The findings (themes and sub-themes) from the interviews were described, interpreted, and discussed in the report. The themes and sub-themes are supported by quotes from participants, and these are reported verbatim. One respondent (Daniela) asked not to be directly quoted.

### **3.2.9. Trustworthiness**

The aim of trustworthiness in a qualitative inquiry is to support the argument that the inquiry's findings are "worth paying attention to" (Lincoln & Guba, 1985, p. 290). Therefore, in this study, attention was given to establishing trustworthiness which included credibility, transferability, dependability, and confirmability during the different stages of the research. Credibility is an evaluation of whether or not the research findings represent a 'credible' conceptual interpretation of the summarised data drawn from the participants' original data. Transferability is the degree to which the findings of this inquiry can apply or transfer beyond the bounds of the project. Dependability is an assessment of the quality of the integrated processes of data collection, data analysis, and theory generation. Confirmability is a measure of how well the inquiry's findings are supported by the data collected (Mazulewicz & Fenton, 2008). During the processes of this research, a number of methods were used to ensure the trustworthiness of the data.

*Credibility:* The process of pre-contact and face-to-face interviews allowed the researcher to build up the trustful relationships with the health providers. An audio tape was used with the agreement of some participants; it ensured the interviews were traceable and re-checkable. The translation and transcripts were done by the researcher herself, as she is

bilingual and understands Chinese culture. The follow up questions were asked to clarify participants' responses and they were offered the opportunity to read the interview transcripts, which ensured the accuracy of the information gained from the interviews. Negative analysis was used to ensure credibility. This involves searching for and discussing elements of the data that did not support or appeared to contradict patterns or explanations that were emerging from data analysis (Lincoln & Guba, 1985). For example, in one service, a Chinese counselor used to work there to deal with Chinese students' mental health issues. The service thought this might be a good approach, because there was someone who could speak their language and understand their culture. However, in fact, the Chinese speaking provider was not often used by Chinese students. The Chinese students tended to avoid him and look for help from a western counselor, possibly because of the cultural barrier provided by the Chinese negative attitude to mental health problems. This represents an additional cultural barrier to Chinese young people seeking mental health care.

*Transferability:* In the study, the participants were purposively sampled from a wide range of health services. The number of nine interviewees was considered to be sufficient to investigate Chinese people's mental health and service use issues due to a relatively small number of possible practitioners who practise and understand the needs of Chinese people in the mental health field in Christchurch.

*Dependability:* During the research, the researcher met her supervisors regularly to discuss the information gained from each interviewee. During the study design, data collection, and data analysis, supervisors provided consistent advice and feedback to the researcher.

*Confirmability:* During the interviews, leading questions to the participants were avoided to ensure the information was not biased by the researcher's point of view. Moreover, this research followed a systematic process during the data collection and analysis. For example, the coding process was based on the close reading of the interview transcripts, and therefore, the themes and sub-themes did not emerge based on the researcher's interests.

## **Chapter 4: Findings: Health professionals' perspectives on Chinese people's mental health issues**

### **Introduction**

This chapter describes health providers' perspectives on Chinese people's mental health and service use issues. Seven key themes emerged from the close reading and coding process: perceived common mental health problems, stressors, high risk groups, supportive resources, barriers, coping and help-seeking models, and possible solutions. This beginning section introduces health providers' overall impressions of Chinese people's mental health and service use issues. Then, the following sections report the seven key themes and their related sub-themes.

Most health providers reported that mentally-ill Chinese people do not often use their mental health services. However, most health providers believed that mental health is a very important issue for Chinese people. In particular, a few Chinese respondents argued that the low utilisation of mental health services does not mean that Chinese people do not have mental health needs, and they have heard of or seen many Chinese people with mental health problems outside the services. For example, Betty described Chinese people's mental health issues as 'an iceberg', because above sea level, it looks calm and peaceful. However, under sea level there are huge problems. She explained her point further:

Actually no problem is a big problem. Low figures of Chinese mental health patients and health services utilisation shown in the health statistics do not mean Chinese people do not have mental health problems.

Ian also stated that "My overall impression is there is a big problem in it." Andrew had a similar expression:

I know the big barrier seems nothing, but is actually a lot. Firstly, because of face and language problems, they might give up. Secondly, in the health research field, because no services were used, so no need is considered for us, but it is not right.

Moreover, the low utilisation of mental health services makes Chinese people's mental health issues hard to understand for western health professionals, and they receive little attention from policy makers. As Frank said that "We do not know what the problems are, because accessing services is at a very very low level. But we do know it is happening, we do know it is out there." Chris also stated that "It is quite hard to tell, because I do see so few Chinese people to be able to form strong opinions."



## 4.1. Perceived mental health problems

Themes	Sub-themes
Mental health problems	Stress Addiction problems: smoking, gambling Relationship problems Anxiety Eating disorders Depression Suicide Psychosis

Through the interviews, the health professionals reported a range of mental health problems amongst the Chinese population. They are likely to be under stress and develop addiction problems, relationship problems, anxiety, eating disorders, depression, suicide, and psychosis. A few respondents stated these issues as follows:

But from my personal knowledge, I know Chinese people do have mental health issues, such as gambling, addiction to alcohol, social withdrawal, and depression is a big problem. (Betty)

We know that smoking, alcohol, drug use and gambling are all issues among Asian people. All lead to mental health issues: worry, concern, fear, isolation. Suicide is a problem. (Frank)

I would say depression and anxiety are the common mental problems for them. We do experience students with gambling. People who are so stressed out and isolate themselves, and they might become psychotic. The reality is different from everybody else, and those sorts of problems. (Ella)

Probably depression is the common problem for them. Also I have come across a couple of patients with psychosis, delusional thoughts, and this sort of thing. (Chris)

During the interviews, stress, gambling and depression were the problems most frequently noted by respondents. For example, for Chinese students, in the different study environment, they might feel isolated and homesick, and they also might get stressed, anxious or even depressed under the pressure of their study. Under these circumstances, Chinese students might turn to gambling and smoking, and these health issues were reported to have a higher presentation than among local students. In addition, Chinese people might develop an eating disorder after poorly managing their diet after significant weight gain in New Zealand. Therefore, this section indicated that under the iceberg, Chinese people do have mental health problems, and stress is the common leading factor in a mental health problem.

## 4.2. Stressors of Chinese people's mental health

Themes		Sub-themes
Stressors	Migration related	Health related
	Expectations from migration Language obstacle Social isolation Cultural barrier Unemployment/under employment	Different health system Personal health

From the literature review, it was found that the majority of Chinese people in New Zealand are migrants and, during the interviews, all the health providers perceived that migration related stressors in their daily living and health related stressors could impact on Chinese people's mental health. For example, Andrew said that "The usual thing is stress, and the more serious things are all for different reasons."

### 4.2.1. Migration related stressors

It is perceived that in the hope of a better life, Chinese people come to New Zealand; however, surviving in a different country is stressful, especially for people from a different cultural background. Expectations from migration, ineffective language skills, social isolation, being in a different cultural environment, and unemployment/under-employment, are the stressors for Chinese people frequently reported by health professionals. As Chris indicated, "Stress and social isolation I suppose are the main factors I can think of." Betty also commented that "Language problems, 'face' problems, and cultural values, are all the possible factors." Moreover, these stressors are more likely to interact with one another to affect Chinese people's mental health. As Ian said:

I think it is because of multiple combined reasons, including the dramatic environment change, unemployment, social position change, the huge change in family life. If the changes become too big, and they are not able to afford or adjust, then their mental health will be affected.

#### Expectations from migration

During the interviews, a few Chinese health professionals noted that high expectations from migration create risks for Chinese people's mental health. The hope of a better life places great pressure on their mental health. As Andrew said, "They come to New Zealand to start a new life, and their expectation is that they should be doing better than what they were where they came from." In particular, the big shift in social status could impact on mental health, as many skilled Chinese migrants were regarded as highly educated and possibly were respected by many people in their home country. For example, a taxi driver may have been a

doctor in China. A dairy shop owner could be qualified with a PhD. Therefore, many Chinese people are believed to be struggling with their lives, and the status of unemployment and under-employment may not reflect the goals they sought to achieve in coming to a new country. The poor social status might particularly affect Chinese people's mental wellbeing.

As Frank said:

It is not meeting their goal of a better life. eg. if you are working as a cleaner, you might feel ashamed to tell the family, and if the family want to come over to visit you, you will feel embarrassed.

### **Language obstacle**

Lack of language skill is considered to be one of the biggest obstacles to resettlement in a new country, and this has been emphasised by a number of participants. In English-based day to day living, language ability is very important for Chinese people in finding a suitable job, integrating with local people, and attending social activities. Even for skilled migrants, whose English ability has been tested prior to their migration, using English for day to day living is quite demanding. Ian, as a migrant himself, stated that "Whatever you have done in China before coming, there is still a gap in language, and it needs a while to practise." Chris added that "Potentially being in an environment of English as their second language, and the stress I suppose from that, means there is difficulty communicating on a day to day basis for some people."

### **Social isolation**

Social isolation is perceived to be another major factor which affects Chinese people's mental health. After arriving in New Zealand, Chinese people are far from their homes, relatives, and friends, so they tend to be isolated and it is very difficult for them to get social support during the resettlement. People who never go out to any social groups might need additional attention and support during the process of resettlement and the situation could be very difficult and stressful for them. As Helen reported, "Usually isolation is the most important problem. Their families are not here, the culture is different, plus the language barriers." Chris had a similar expression:

I think for the people I have seen over the last few years, social isolation and the distance from family members are often a big factor. Having been in New Zealand, for most of their life, with their family maybe overseas, whether in China or wherever, I think it often has quite a big impact on mental health.

### **Cultural barriers**

Cultural familiarity was reported as a key determinant for fitting into a host country and keeping healthy. However, the respondents perceived that people coming from a different cultural background have different sets of values and different ways of doing things. One participant explained how the cultural attitudes to hospitality differ, and gave the example of how Chinese hosts always provide food for guests but in New Zealand often that responsibility is shared through 'pot luck' arrangements. Sometimes this seems awkward and inappropriate to Chinese people. Moreover, in the different cultural environment, all these new things and cultural conflicts could make Chinese people feel stressed and could become potential risk factors for Chinese people's mental health. For example, Gay, as a migrant herself, commented on her own feeling about resettlement "Totally new, I had no idea. So it was very stressful. I had never thought about these [things] and I do not want to go through these experiences again because it was so hard." Chris, as a western provider, agreed with that, "But also I think living in an environment, perhaps differently or confusingly to culture, additional stress from that." Moreover, the poor trans-cultural skills are often associated with a high risk of mental health problems. Andrew gave an example, "Under these pressures [ie. social isolation and unemployment], a few of them went to gambling, and thought gambling could make them fast money and they could get rich quickly."

Two Chinese migrant providers indicated that even many small things might add stress to Chinese people's daily living. As Gay reported:

Sometimes it could be stressful for us as well, because of so many new things. I was not really enjoying exploring the new things. With all the new things, I did not feel comfortable because I did not know what I was supposed to do or what kind of things I could expect. So I think probably many migrants are not quite sure as well.

In the new environment, they might want to continue their ways of doing things which might not be possible. For example, they might prefer gas cooking to electric cooking or using an oven. Other things could be different; driving and shopping styles, driving on the opposite side, having few open markets to go to, or being unable go to the market as often as in China, or having less familiar food. Therefore, all these differences could impact on their mental health.

### **Unemployment/under employment**

The health providers indicated that to survive in the new country, finding a suitable job is essential, and that job-related socio-economic factors relate directly to income and

quality of life. Having a satisfying job could provide Chinese people with enough money to live in a healthy house, offer a comfortable life to their family, and build up their confidence, so that they feel they are contributing to the new country. However, in the labour market, Chinese people have many difficulties in finding a satisfactory job because of language and cultural barriers, low recognition of their past qualifications and work experience and possible discrimination in the labour market. For example, Andrew said that “Because of language barriers, and also maybe there is bit of racism in employment, Asians do not get employment easily.” Frank said that “There is lots of discrimination here, eg, if you have an Asian name and you apply for a job, you probably will not get an interview. It does not matter how good you are.” Gay also commented:

It [employment] is one of the biggest problems for Chinese migrants because it is very hard to get a [satisfactory] job which is comparable to what they normally do in China. Though they [qualification and work experience] are recognised when we applied for migration, after moving to New Zealand, I do not think they help in terms of finding a good job.

Owing to the difficulties in the labour market, many Chinese people are under the stress of under-employment, or even unemployment. It is likely their living status cannot meet their expectations. As Ian said, “Loss of social respect, people look down on you, problems with living, you have to depend on the government benefit for living.” Under these circumstances, Chinese people might feel regret in coming to New Zealand, or lose confidence in their new life or even have mental health problems. Betty reported:

Because some people are highly educated in China, they do not want to do labouring works. After coming to New Zealand, because they were not good at English communication, they could not find a good job. That brings depression and social isolation.

#### **4.2.2. Health related stressors**

##### **Stress from a different health system**

Respondents reported that currently in China people receive their medical care very differently compared to New Zealand. As Frank said:

Every country is different. Asian countries are lot more different because they have different health systems. We have a primary health and secondary health system. But in country like China, you do not have this. You go to hospital straight away. You do not have family doctors.

After coming to New Zealand, many Chinese people might be unaware of the differences in the health care systems between New Zealand and China and this is a likely

source of stress for many. For example, Ian stated that “Here GPs and western doctors are the first choices for every patient, and this is the system here.” The quality of care that Chinese people receive may be affected by inadequate knowledge and unawareness of the existing services. As Frank said that “There are a number of Asian people not enrolled with doctors, because they do not understand the health system or they are healthy.” One of the reasons for that was perceived as Chinese people probably not realising the importance of enrolling with a GP. However, if they do not enrol, it is more difficult for them to get primary health care.

The appointment-based health care system creates additional stress when they access services. At the beginning of the interview with a Chinese provider, he indicated that if possible, he offers his service immediately to his clients, because he understands that in China no booking is needed and, actually, during the interview, the conversation was interrupted a few times by the clients’ phone calls.

A further concern is that for Chinese people who prefer Chinese medicine for their treatments, this may not be accessible (more information in Section 4.5.2 Barriers to TCM). Two respondents reported as follows:

A few Chinese still do not believe in western medicine, they prefer Chinese Medicine. Sometimes they try both. This because they believe Western Medicine only can stop the symptoms, but Chinese Medicine can uproot the illness. (Andrew)

Maybe they want to be treated in that way [traditional Chinese medicine], and not have western medicines, that is fine. But if they cannot access to the treatment, so they cannot get it, then the worry will be not having any treatment. (Chris)

### **Stress from personal health**

The World Health Organisation states that both physical health and mental health are very important to people’s mental well-being (WHO, 2011b). Without good physical health status, mental health will not be achieved. During the interviews, some respondents reported that the stress may not come only from the barriers of language, culture, isolation and employment, but also from their physical or mental illnesses as well. Moreover, they are likely to be inter-related and influence each other. Gay commented on this issue:

I think physical health and mental health are interrelated. If they do not eat well, then their general health status will deteriorate, and this will impact on their mental health as well. When you feel bad, you do not want to cook, no energy at all. You do not have enthusiasm to do nice things for yourself or other people. And then if you do not eat well, you have less energy, and do not want to try new things or socialise. And then it becomes a vicious circle.

Once people suffer from health problems their mental health is likely to be affected. For example, if a young girl has an unwanted pregnancy and she does not want her parents to know, she might feel fear and stress. Some Chinese people who were diagnosed with cancer might, because of their fear and cultural barriers, refuse treatment. Therefore they might miss the best time for their treatment, and poor outcomes result. Under these possibly poor physical health risks, Chinese people's mental health is likely to be affected. However, a few respondents also indicated that many physical diseases and mental illness are avoidable and treatable. If Chinese people could appropriately access health services, their health, especially mental health, could be improved.

### 4.3. High risk groups

theme	subthemes
High risk groups	Chinese elders Chinese students People in between Isolated people Unwell people from China

During the analysis, besides the group of Chinese elders which were identified in the literature review, other specific groups at high risk of mental health problems emerged from the close reading of interview transcripts, including Chinese students, 'people in between', isolated people, and unwell people from China.

#### 4.3.1. Chinese elders

The mental health of elderly Chinese people was emphasised by most health providers because they are a particularly vulnerable group in the Chinese population. At home they are likely to take responsibility for looking after the family, for example, looking after their grandchildren, and cooking for the family. However, taking care of a family is not as easy as in China. For example, many Chinese old people do not know how to use an oven and they prefer to use their familiar fried cooking style which might not be available. Others like particular ingredients, vegetables, or fish, but might not get them, or they cannot get them as often as they would normally do. Moreover, the health providers perceived that in the new cultural environment, Chinese elders might suffer from intense isolation because of their poor language skills and transportation problems. Without help, it could be very difficult for them to go out and mix with local people, and even access health services. They are the group least likely to build up supportive connections in New Zealand's western culture. All these reasons

put pressure on Chinese older people's mental health, and may lead to low access to health care. For example, Helen said that "The majority of Chinese old people cannot speak English. During the day, their children go to work and leave them at home, so they are very isolated." Gay also commented:

For Chinese old people living in New Zealand, I think the most important thing is the language barriers. From my experience, also my observation, some of them may be very isolated because in a new country, they do not know many people in New Zealand. Many of them cannot drive, so maybe if they want to go to some social activities, because of lack of transportation they cannot go.

#### **4.3.2. Chinese students**

During the interviews, Chinese students were identified as a special group within the Chinese population. They are more likely to have better English language skills and intercultural skills. They tend to adapt to the new cultural environment faster and more easily accept new things, be more open-minded and seek help from mental health services. For instance, Ella reported:

Probably, every second day I see a Chinese student, because if I look at my case load, say I see five people a day, and of my case load probably one is an international person, somebody from a different ethnicity, and half of them are Chinese. I would say the representation of Chinese students with mental health problems is just like that of the normal Kiwi students.

However, although Chinese students tend to be quick adapters in the new cultural environment, they are also at risk of mental ill-health. Besides the common resettlement issues, they have pressures related to their study from different sources, including the pressure of course work, pressure from their family's expectations, pressure from the isolated new environment, and pressure from not having enough money. Moreover, if the student is an adult with young children, their situation might be even more difficult and stressful.

Different cultural approaches to study could place great stress on Chinese students' mental health as well. For example, asking questions and offering a personal contribution in class is much more valued than in China, and Chinese students might not be good at these skills. Hard work and ability to memorise, which are the strengths of Chinese students, are less important in New Zealand. These differing values are likely to make Chinese students feel stressed. Gay, as a migrant, commented on her own feeling about studying again after migration:

But here in New Zealand I felt it was a shock for me. It is so different, and I feel it is really hard. I am not really good at doing these kinds of things. You need to make a lot of adjustments to be able to feel good, but to be honest I think maybe 80 per cent



or 85 per cent of my studying time, I did not feel good at all. It was very stressful and I think I was very anxious, probably a little bit depressed as well.

For students whose family is in New Zealand, they might lose their study time to look after their family members because they have better English skills than the other members in the family. This could create additional stress in their lives. As Ella said:

Some of the students have to take responsibility [for their family] when they are studying, and the family things can make the students stressed out. It is really frustrating for them, really really big stress, because they feel like they have to cope with everything for their family. So the student is missing lectures to go along and help their family.

For students whose family is not in New Zealand, they might suffer intense isolation. If they experience difficulties and troubles in New Zealand, they would normally not tell the truth to their families in their home country, because they do not want to bother them, and their parents are less likely to understand their situation, or have the ability to help them.

In addition, after coming to New Zealand, young Chinese students have greater freedom, and there are many temptations outside their study, and they might not be able to cope with those attractions. For those who are used to being looked after by their families in China, they might lack the ability to live independently. For example, they might not know how to manage their own lives and how to deal with daily living. All these factors affect young students' mental well-being. Ella gave an example:

Quite a group of Chinese girls are here and they do not know how to go flatting, and they do not know how to cook, they do not know how to look after themselves, they do not know how to do the washing. Because their mum has done it. They may be in relationships with boys who are looking after them and providing everything for them. When the relationship breaks up, there is a mess, because they do not know how to look after themselves in New Zealand for one minute, they are so dependent, and it is really scary.

Therefore, although Chinese students might come from very different backgrounds, all these stressors could undermine Chinese students' mental well-being, and put them at a higher risk of mental health problems.

#### **4.3.3. People 'in between'**

Participants described a group of people who belong to neither western culture, nor Chinese culture. Moreover, if they are isolated in the country, they are less likely to get help to get out of the situation. They might be young people growing up without family in New Zealand, they might be second generation Chinese migrants, or they might be new migrants

who cannot adapt to New Zealand life. For example, a young Chinese girl whose parents were divorced when she was aged 14, was sent to New Zealand to study. After boarding school, she studied at university, and she had not lived in China for many years. When she went back to China for a holiday, she lived in a hotel, and she had no friends there. When her life went wrong in New Zealand, she had no support. Therefore, Ella commented:

But what happens to these people, they do not belong to the Kiwi culture, and they do not belong to Chinese culture either. So they are stuck in the middle. So it is very hard for them to get support.

Betty also reported that “She [a young lady who came from China] could not adapt to the New Zealand life, so she went back to her home country, but she still could not adapt to life there. It becomes a vicious circle.”

The second generation of Chinese young people might be confused about their parents’ Chinese culture and their friends’ western culture, and the cultural conflicts possibly impact on their mental health. For example, Gay reported:

Some second generation Asian young people are a kind of a group of people in between. Their Chinese parents want them have Chinese food, and also practise the Chinese culture, but they also have their Kiwi friends, and under peer pressure, they want to be part of their friends as well. But if they are not very well managed, then I think the group in between will always have a high percentage of or be at high risk of developing mental health problems.

#### **4.3.4. Isolated people**

Isolated people could be elderly Chinese people, students living alone, or they could be the new migrants. This group have been identified because they do not have many connections and because they are so quiet, they are less likely to get support, and tend to be ignored. Two respondents commented as follows:

Then, the introverted people tend to be isolated as well. They stay at home, do not speak, do not talk to people, and they do not have friends around them. Especially, the New Zealand winter is cold and dark, and if they do not know how to keep themselves warm, their day becomes very long, and it is very hard for them. (Helen)

I know a lady, who was from Asia, because she could not communicate well in English, she became socially isolated, lacked energy, motivation, and then had depression with hallucinations. She stayed at home for most of the time. (Betty)

#### **4.3.5. Unwell people from China**

Two providers reported that mentally unwell Chinese young people have been sent to New Zealand by their families in China. Their family expected that the young people could get well again when they changed to a different environment. However, the health providers

pointed out that it might actually make their mental health problems worse, or they are at high risk of recurring. Being in a different country, they tend to be isolated and less likely to get support for their mental health issues. As Ella commented:

Anytime anything goes wrong, it becomes a major issue for the person isolated at home. In the flatting situation, it really is upsetting to all the flat mates. Not getting to university. The psychiatric emergency service might be involved because the person said they are going to kill themselves. The family do not even know what is happening. There might be a relationship, there is a boy who is involved in the background, so he gives up. And so the person is completely stuck. It is not a common situation but it is a scary situation for everybody.

Moreover, if they are international students, they might face extra financial difficulties because the students' insurance does not cover a pre-existing illness, which means, for example, if a student with a history of schizophrenia in China experiences a re-occurrence in New Zealand, the insurance will not cover any treatment and medication, and the students have to pay for treatment themselves.

#### **4.4. Supportive resources for people with mental health needs in Christchurch**

<b>Theme</b>	<b>Sub-themes</b>	
<b>Supportive resources</b>	<b>Support from mainstream services</b>	<b>Other factors</b>
	General support Specific support	Openness and flexibility Supports within organisations Trustful therapeutic relationship Family Church Helpful experience Financial factors Resources and help from Auckland

##### **4.4.1. Support from mainstream services**

###### **General support**

Over the time of the interviews, the researcher identified strong supportive services and support for people with mental health problems in Christchurch, even though these services are not always taken up by Chinese people. A wide range of mental health services are available from general practitioners providing primary mental health care, to psychiatrists providing specialist care, as well as community based mental health care, from intensive emergency care, to rehabilitation services, and from medical support to social support.

Moreover, these services are well coordinated to meet people's mental health needs, they can refer clients to each other, or to other appropriate health organisations. For instance, the Mental Health Education and Resource Centre, and the Mental Health Foundation offer mental health related information to Christchurch people. Gay also said, "The Community Health Information Centre is part of CDHB services under the Community and Public Health. They have all the health related resources there, and it is free for the public within Canterbury." Helen stated how clients get support from primary mental health services, she said that "In the emergency situation, we can call the emergency service, and send them to the hospital for treatment. If they can come to see us, we will treat them in our service, and make sure they are alright." In specialist mental health care settings, much support surrounds a client, including a psychiatrist, psychologist, physiotherapist, counsellor, nurse, as well as a social worker. As Betty stated:

We always work in a group. In the hospital, a patient can get medications, and professional health providers surround the patients. Psychiatrists, psychologists, counseling, and physiotherapists [because sometimes physical problems will worsen the mental health problems] are all around the patients to support them. Social workers will support patients to deal with finance or house problems. Also hospitals have discharge plans including informing the GP, and community services. After that at Princess Margaret Hospital, there are some rehabilitation programs.

### **Specific support for Chinese people**

A few respondents reported that in recent years, some resources for Chinese people have been gradually building up. In the research field, a few studies have taken place on the Asian population. Some services recruited Chinese health professionals to support Chinese people's health needs. For example, the clinic of Doctors on Riccarton is serviced by (New Zealand) Chinese doctors, and another New Zealand Chinese GP is at the Waimairi Road practice. Quite a few Chinese medicine providers (acupuncturists) are practising TCM in Christchurch. There is also a Chinese provider working with women's health. Some Chinese students are in nursing. There are educational programmes in Chinese communities, for instance, cooking classes and nutritional assessment. Moreover, all participants reported that they have attended educational seminars about cultural needs for different ethnicities, and how to treat clients from different ethnicities appropriately. While there are still insufficient resources to support Chinese people's mental health issues (see Section 4.5.2), some Chinese-specific services are now becoming available. For example, Ella indicated that "As a whole problem gambling, there is a voluntary organization that deals with them, and there is a

service just for Chinese people, it is definitely set up there.” Chris said that “There is a Chinese phone line, they can ring if they feel they are under stress, I think they can talk to Chinese people.” Frank also stated:

We actually speak to groups of Chinese and Korean people on Saturday mornings. We have done a quite lot of this over the last 2 to 3 years. We will start it again after Christmas, talk to people about where they can go to get help. We advertise in the Chinese newspapers. We never charge for this. We can do mental health, we will be moving into this area (it has come up in conversation before, we talk about it, but we have not done anything specific on mental health). Next year we are going to look at diabetes and chronic disease, and clearly there will be mental health issues.

#### **4.4.2. Other identified supportive factors for Chinese people**

Besides the available mental health and support services themselves, a number of potential supportive factors were identified which might support Chinese people access services and get quality of care.

##### **Openness and flexibility**

The health providers reported that, in mainstream health services, the openness of both clients and health services can help Chinese people to get appropriate mental health care.

##### ***Openness of the services***

The respondents reported that the openness and flexibility of the mental health services are very important to meet Chinese people’s mental health needs. For example, Ella said that “We are quite open in what people want to do with the time spent with us, we just give people lots of space to meet what they need. The openness is quite obvious in having fewer barriers.”

Chinese people are possibly not familiar with the appointment-based health system, and sometimes they might come directly into the services. Under this circumstance, if the health service can treat them in an appropriate way, the Chinese people will receive good care. For example, one Chinese participant emphasised that if somebody rings up his service, he would pick up the phone and help his clients as his priority, because Chinese people need a lot of courage to come to the service. If he missed the calls, some Chinese people might give up seeking help.

Two western participants noted how they support Chinese clients’ health needs in their appointment-based services. In a normal situation, people need an appointment, but if somebody really needs to be seen, they will assess the situation, and then decide how urgent it is to see them. For counseling they usually will give them an appointment within a day.

Medically they would usually give them an appointment within that hour. So their clients would be appropriately treated.

Moreover, a few other ways were indicated that might be useful in meeting client needs in the services. No session limits on counseling might be more suitable for Chinese people, because they are likely to respond quite slowly. As Andrew stated:

Some places have a limit of six sessions of counseling but we do not have that limit which is good. Because some people recover quickly, some people take a longer time. So setting up limits of six sessions is not useful for the Asian clients because maybe on the sixth session, they start wanting to tell their story.

A Chinese counselor noted that his service has expanded to be more flexible to suit Asian clients' needs by adding social work to the existing counseling services. A western counselor pointed out that to give more space to Chinese clients might be a useful way for Chinese people to get good support in their care.

### *Openness of Chinese people*

Although the openness is very important for the health services in meeting Chinese people's mental health needs, a few respondents pointed out that the openness of Chinese people is also essential for them to receive appropriate mental health care. With openness, Chinese people could feel more supported and willing to get help in the mental health services. In New Zealand, health providers are not allowed to force their clients into a treatment, and the clients themselves have to choose to be treated. Moreover, unless a person is ready and willing, they will not change themselves. For example, Frank said:

If you know a friend abusing alcohol, you cannot force your friend to see a counselor. The friend has to make the decision by themselves. You can suggest to them, you can tell them or you can do whatever, but you cannot force them.

However, the respondents also stated that if Chinese people are open to the mental health services, then they are more likely to be supported. As Helen reported:

Sometimes they can come back by themselves. For example, we have a Chinese patient, and because she is very open to her mental health problems, when she feels depressed, she will come to see us by herself.

Especially if Chinese people are open to the new cultural environment, they are more likely to build up social connections and adapt to the new life more quickly and easily, therefore, preventing them from developing mental health problems. As Gay said:

If they go to the cooking class, they can make some new friends, and they can learn some new cooking styles. By this means they are more interrelated into New Zealand culture or into the new country; they feel good about these new things, and they feel better about themselves.

### **Support within a practice location**

From the literature review (Chapter 2.4.2), it is clear that Chinese patients are more likely to register with just a few general practice locations in Christchurch, including Doctors on Riccarton, and the Grahams Road Surgery. Through the interviews, the researcher discovered the reason for that is because those practices have Chinese language speaking staff, thereby reducing the language and cultural barriers between health providers and the clients (Section 4.5.1). Therefore, that might be a strong reason for Chinese people enrolling with them. Frank indicated:

In the Grahams Road Surgery, the GP can speak Chinese, and it also has other Chinese speaking staff. Doctors on Riccarton has a Chinese GP, and they can handle 8 different Asian languages, because they have staff who can actually deal with that.

Another important service provider for Chinese students is the Student Health Centre at the university. Two participants indicated that language is less of a problem there for two reasons. One is that Chinese students at the university generally have quite good English skills. The second is because the university has its own internal network and support services. People from international students' support, and tutors from language schools could all assist with any language problems.

### **Trustful therapeutic relationship**

In the interviews, both western health professionals and Chinese health professionals emphasised that building a trustworthy and reliable relationship between health providers and their clients is essential for Chinese people in accessing mental health services. Owing to the concern of safety and privacy, Chinese people might not want to tell doctors their mental health problems. A few participants highlighted this issue in the interviews. Examples from Betty and Andrew are as follows:

Building up the trusting and therapeutic relationship is very important, including the health professional's attitude to their patient, and effective listening skills, communication skills, empathy, and respect. Once the trusting relationship has built up, the patient will talk more about their problems, such as the reasons for depression, so we can know what treatments or support are more effective for them. (Betty)

Mostly I have to reassure them that what we talk about here is safe, and I cannot tell anybody to make sure they can trust me. News is not go out from here. That is what I mean by building up the rapport and trust before they say something. Especially for Asians, it might take a few sessions before they really trust you, and tell you things. (Andrew)

### **Family**

A few providers reported that in the different cultural environment, the support from family is vital in caring for Chinese people with mental health problems. Their close family members were identified as a strong support for them overcoming mental health issues and living in the society. As Helen reported:

Here there are fewer people, and they can be forgotten, unless they have family support. Asians tend to support their patients at home, if they can cope. We have a Taiwanese patient with grown up children. She is so depressed, and she stayed at home and did not talk for a long time, so her husband came here to ask for help. Her husband is very good. He took time off from his work, and took her here or there. So as long as you have a supportive family member, the patient will be cared for.

Moreover, Chinese people who have mental health problems are likely to stay at home, and be cared for and supported by their family. Especially, during the help-seeking process, their family members are commonly the first to contact the mental health services.

### **Church**

Outside the mental health services, support from the local churches for Chinese people was reported by a few health providers. The local Chinese churches are expected to have higher Chinese populations; therefore, these might be useful places to approach Chinese people, especially for health education purposes. For example, educational seminars for Chinese people are sometimes arranged in a Chinese church. A participant also reported that when she did assessments with Chinese people, one of her ways to reach Chinese people was to go to the local Chinese churches.

Moreover, church friends are likely to offer their help to people who have mental health issues. Often a Chinese client is accompanied by a church member when they come into the services. For example, Ella said:

The other people we have been contact with, or contact us would be from the church. That seems to be within the Chinese community, a lot of Chinese students getting support through the different churches here, the local churches. So I have seen several with church members come into the sessions, or grab the church member who has contacted me or the urgent duty person, often they are getting that kind of support.



### **Helpful experiences**

Several respondents reported that their own working and living experiences are all very helpful in understanding Chinese people, Chinese culture and their mental health issues, and therefore, helping them offer efficient services to meet Chinese people's mental health needs. For example, Frank said that "I have been working in health for over 30 years. I have lived in many countries. I lived in China for 3 years. That is why I understand why people certainly have problems when they come to New Zealand." Andrew also said, "Because I have been working as a social worker for the last 15 years, and I have also lived in Christchurch for 33 years, I have good networking."

In some services, although staff are not Chinese speaking, because they have acquired rich knowledge from their experience, they are very confident and competent to treat their Chinese clients and make them comfortable in the service. For example, young people from China may often be the only child in their family, and therefore their parents are more likely to have very different expectations compared to New Zealand students' families, and may seem more concerned or worried about their child. Therefore, understanding their different family background might be very helpful in serving Chinese students. For example, Ella comments:

Our experience helps. I have seen many Chinese students talking about all sorts of difficulties of their relationships with their parents at home. So that alerts me that could be what the person trying to explain to me. So the counseling experience helps. A kind of heads up what might be happening. Some experience also comes from my Kiwi culture. Such as my experience as a daughter and as a mother.

### **Financial factors**

The health providers reported that the cost of health services is another vital issue for people in deciding whether they will access services. According to the literature review, Chinese people are among the lowest income groups, and if the health service is too expensive, they probably give up the treatment. Fortunately, many low cost or even free services have been identified in the health and mental health area in Christchurch through the interviews, including health related free interpreting services, free counseling services, free services at public hospitals, and free information for local people. As Ian said, "Here the government pays all the medical fees, or insurance pays for the treatment, even when you buy from a pharmacy. Or even in hospital, they pay for everything." Frank also said:

There are free services out there that the patient can actually take themselves to. For example, there are free counseling, free legal aid, there are some free health services through places like women WVA, there are several women's health places,

all free. Sexual health is free for people under 21 years. Everybody can go to the family planning clinic, and get free advice and free help.

Low cost insurance was perceived as a vital resource for meeting students' health needs. The Student Health Centre commonly has an arrangement with insurance companies, so students do not have to pay money from their own pockets to get appropriate medical treatment. Moreover, the insurance covers not only health care, but also a range of things, including going home if there is a problem with parents, or losing personal possessions. Therefore, the low cost could be a vital element for a successful practice.

### **Resources and help from Auckland**

During the interviews, nearly all the interviewees were aware that the Auckland region has a much stronger supportive environment than Christchurch, with more culturally and linguistically appropriate services, more research into the Chinese population, more information available in Chinese, and more planning of specialist mental health services for Chinese people. For example, Ian said that "I saw from the newspaper, Auckland is going to establish a hospital, and work for our people." Frank said that "In Auckland, they recognized that 10 years ago. They have culturally appropriate services in Auckland, but we do not have down here. Auckland has them." Andrew added that "There are in Auckland, all sorts of Asian services, and the information on Asian mental health services in Auckland can be gotten through the Mental Health Foundation's website." Moreover, 'Cross-culture Resources' information from the Waitemata District Health Board (Auckland) was perceived as very useful in helping health practitioners to understand people from different ethnicities and their health needs.

The health providers are not only aware of the culturally appropriate services for Chinese people in Auckland, but they also noted that Christchurch is actually getting help from people from Auckland. An example was given by Betty, "I know Auckland have, because they used to [come] down to Christchurch, and had a seminar of Kai Xin Xing Dong, talking about mental health issues in the Chinese community." Two more examples were from Chris and Frank:

There is a doctor who is a psychiatrist, working in the North Island, who is very much into culture, specifically he is a psychiatrist dealing with Chinese people with mental health problems from Auckland. And he has had workshops in Christchurch. (Chris)

I get more help out at the Waitemata District Health Board which is in Auckland, than I do from the Canterbury Health Board. Because the Waitemata District Health Board

has done lots of work, and they are quite happy about giving us the copies of what they have done. I know a number of people working out of there more than happy to help, so it is quite nice. (Frank)

#### 4.5. Barriers preventing Chinese people from getting appropriate mental health care

Theme	Sub-themes	
<b>Barriers in the services</b>	<b>Barriers for Chinese people</b>	<b>Barriers to services</b>
	Language barriers in health services 'Face' and shame issues Lack of knowledge and awareness Complaints about physical health problems	Lack of attention from policy makers and funding support Existing model does not suit Cultural differences Lack of resources in Chinese TCM

Although the respondents reported that many mental health services are available to support people with mental health problems, they also reported that Chinese people are less likely to seek help from mainstream mental health services (reported at the beginning of this chapter). Therefore, to identify the reasons for low service use among Chinese people, the questions about practice related barriers in the mental health services were asked of the health providers during the interviews. Then, a series of barriers were reported from two perspectives. On the one hand, there are barriers from Chinese people. On the other hand, there are barriers from the health services.

For example, one Chinese provider reported that when she was studying after migration, she had very itchy skin, and only years later did she realise that it was due to her stress. In the primary health service, the GP did not recognise her mental health issues, so no support was offered to her. This example might be true of other Chinese people who experienced mental health issues. Firstly, poor mental health knowledge among Chinese people means they might not be aware of their mental health status. Secondly, Chinese people might have different presentations for their mental health problems: stating a physical health problem instead of mental health issues (itchy skin instead of stress), therefore, health providers might not be aware of that, and under-diagnose Chinese people's mental health issues. Consequently, Chinese people might not be given enough support, especially in primary care. Therefore, these reasons are more likely to influence each other and lead to low service use issues.

#### **4.5.1. Barriers for Chinese people**

##### **Language barriers in health services**

Language was reported by the majority of respondents as one of the key barriers preventing Chinese people from accessing mental health services. They emphasised the importance of communication in mental health care settings. In English-based mainstream mental health services, without good language skills Chinese people might not be able to use these services. Especially, concerns arose about the effectiveness of communication with health providers. Moreover, even though Chinese people know that mental health services exist; owing to language barriers, they might give up going to the services. As Gay stated that “I think in New Zealand, we have quite good health services, but the thing for them is, it is quite difficult for them to use these services, again language.” Andrew also said:

For the mental health problems, actually I have nowhere to send them because of language barriers. I know a few families face Autism problems, and Christchurch has this service, but because they cannot communicate, and if I do not help them, they will not come in to the service.

However, if Chinese clients have good English skills, it could be much easier for health providers to support them, because the provider could refer them to different services to support their mental health needs. For example, Helen said that “We had a patient recently, and because her English was good, so we referred her to do the counseling. However, if their English is not good, and then there are not very strong supports.” Respondents also noted that difficulty in communication could add stress to both health providers and their clients. An example from Ella:

If their English is not good, we just take a lot more time. It takes more time and it is tiring for us, because it is not easy work. Listening to somebody who has trouble with telling us what is happening, it can get frustrating as a counselor, just like getting frustrating for the person who is trying to tell us, and we are there, in the room, for 50 minutes listening to somebody who has trouble talking to us. However we do kind of muddle through in the end. I do think it is a good outcome in the end.

##### **Stigma and shame issues**

The shame and stigma issues were perceived as another key problem for Chinese people. Chinese people tend to have negative attitudes towards mental illness and its patients. For example, in China, the mental health patients are cursed by calling them ‘Feng Ren’ or ‘Shen Jing Bing’ (means mad people). Moreover, ‘face’ and shame issues have also been considered as a big obstacle, which might affect Chinese people seeking mental health services. Chinese people possibly avoid admitting that they themselves or their families have

mental health problems, and then do not go out to seek help. Gay, who is a Chinese and grew up in China, said that “But for Chinese people, our understanding of mental health issues is 家丑不可外扬 [Do not wash your dirty linen in public].” Two western respondents also had a similar expression:

I think for Chinese people this is a stigma about counselling and the stigma is around mental health. I have not been to China, but my understanding is that if somebody said they are depressed or they are anxious in China, and there is not much help for them, it is a big deal. (Ella)

Because in many Asian countries ‘face’ is involved, people will not seek help because they do not know what is out there. Because in their own countries, people think there is no other way. Many of them will not seek help because they lose face. Even if they might know the health service exists; face is lost by accessing it. (Frank)

Interestingly, one participant reported that in one service, a Chinese counselor used to work there to deal with Chinese students’ mental health issues. The service thought this might a good approach, because there was someone who could speak their language and understand their culture. However, in fact, Chinese students tended to avoid him and look for help from a western counselor. The reasons for this were thought to be that, besides good English skills among university students, the negative cultural attitude to mental illness might have affected Chinese students’ help-seeking behaviour. The Chinese students might have felt embarrassed to talk to a health provider who is from the same ethnicity. This represents an additional cultural barrier to Chinese young people seeking mental health care, and all these reasons might lead to a low use of mental health services.

### **Lack of knowledge and awareness of mental health and its services**

During the interviews, a few participants indicated that many Chinese people have a poor understanding of western medicine-based mental health knowledge, and they also might not be aware of the existing mental health services in Christchurch. This might be another reason for Chinese people not seeking mental health support from mainstream mental health services.

On one hand, Chinese people might lack mental health knowledge, therefore, they might not be aware of their mental health problems. For example, because of poor knowledge, a group of Chinese young girls were using ‘P’ to keep themselves slim, but when they realised their addictive problems, it was already too late to stop. Betty’s example about depression also showed poor mental health literacy among Chinese people and she said:

Lack of knowledge about themselves, for example, they only think they are normally blue, but they cannot realize they are already depressed. Sometimes, Chinese people think it is not a big problem. But actually, if someone experiences social withdrawal, it will be an early sign of depression. Their family would think it is not bad if someone stays at home instead of going out and doing some mad things.

Moreover, many Chinese people might misunderstand mental illness, and do not know how to cope. For example, a group of young Chinese people who already had mental health problems were sent out by their family (reported in Section 4.3.5). A father reportedly was beating his young daughter (who had an eating disorder) because she did not eat. Frank also commented:

You know yourself in China, somebody with mental health problems, they are seen to be crazy, but it is an illness and it is treated in New Zealand as such. However, we know there is an issue with mental health services, and people coming in from Asian countries. We talk about China, Korea or Japan, all those sorts of countries, mental health is not seen as an illness in many of these countries.

On the other hand, Chinese people might also lack awareness and understanding of health services. Most participants indicated that although good health services are available for Chinese people, they might not know where they are and how to access them. As Gay said that “So many of them are not aware of the available health systems or how actually they can access the services.” Helen also said that “They also lack of knowledge of services, they do not know where, when, how to get help.”

### **Complaining about physical health problems**

From the health providers’ understanding, when Chinese people come to their services they are likely to complain about their physical problems instead of their mental health problems. It might be because of cultural barriers, poor mental health knowledge, or low awareness of their own mental health status. For example, Ella and Ian’s comments reflected this theme:

A lot of people present and they have physical symptoms. But often their physical symptoms are really the symptoms of depression. And a lot of people come with problems of sleep; it would be the most common presentation. You know when you get depressed, you cannot sleep well. (Ella)

But normally, they do not complain about their mental health when they come to me. For example, over fear and shock can cause mental problems, and also physical problems. The patients commonly come with the physical problems. After the earthquake, some patients did not eat, did not sleep, and wherever they stayed, they would feel shakes, and were not safe. A patient, when he slept had to sleep under a

table. So the earthquake caused mental problems and physical problems, and my patients would come because of their physical problems. (Ian)

Moreover, mental health and physical health are likely to be inter-related and influence each other (see Section 4.2.2). Owing to cultural barriers, Chinese clients might feel more comfortable sitting in front of a doctor and talking about their physical health problems, but underlying that, they actually want to talk about their mental health issues and to see how health providers receive them. Together with other cultural barriers, for example indirect questions (do not say ‘depressed’ directly), if health providers do not understand the specific presentations of mental health problems for Chinese people, their mental health problems are possibly ignored in the clinical settings.

#### **4.5.2. Barriers to health services supporting Chinese people’s mental health needs**

A range of barriers in the services were reported by the respondents which might lead to the low access by Chinese people. These include lack of attention to Chinese people’s health, especially mental health issues, lack of available funding support, the current mental health system not suiting Chinese people, not enough cultural and linguistic specialist mental health services to support Chinese people, and barriers to accessing traditional Chinese medicine.

##### **Lack of attention from policy makers and funding support**

A few participants indicated that Chinese people’s mental health is an area of lack of attention from policy makers, because many of them do not believe Chinese people have mental health problems. As Frank said that “Acceptance by the CDHB, we have problems with that. This is a direct quote ‘all Asian people are healthy and wealthy.’” Gay’s comment went further:

There are quite a lot people who make the decisions, high up there, they are not really aware of health or mental health related issues among Asian people or among Chinese people. I think quite a lot of them think Chinese people are healthy because they do not go to GPs, they are all fine. Why we are trying to know them more.

One reason for the lack attention from policy makers was reported to be the small proportion of Chinese compared to the total Christchurch population. As Chinese people have a lower population percentage in Christchurch than in Auckland, Chinese people’s health, especially mental health is ignored by policy makers, and therefore, there is little policy

support and funding given specifically for Chinese people's health. However, without a supportive policy and funding, it is too difficult to set up specific mental health services for Chinese people. For example, Andrew said:

The most important thing is no specific services, and if there was more funding, we would start Asian specific services. We could employ people who fit the job, and help. And we need more professional people involved, and they cannot keep doing volunteer works.

In comparison, a few respondents reported that there is a group of people who care about Chinese people and work hard for Asian health, including Chinese people's mental health issues. As Gay said that "I think in terms of services or health related services for Chinese people I am not saying it is specifically my job, many people are very enthusiastic about Asian health." A group of people formed Asian Health Canterbury. However, because of lack of funding, it is very hard for them to work towards Chinese people's health, especially mental health. Frank commented:

The problem is that we get a certain amount of funding for refugee people, but we get no funding for migrants. Canterbury is one of a few areas that do not get funding for this, because the District Health Board just does not believe that Asian people have health needs. They believe Asians are healthy and wealthy, which is wrong.

### **Existing health system does not suit**

Several health providers indicated that although there are many good mental health services in Christchurch, the current mental health system might not suit Chinese people's needs. In mainstream mental health services, certain pathways were established to support people with different needs. However, these patterns might not be efficient for Chinese people. For example, Gay said that "They have their model of care, or their standard approach, to treat their European patients, but it does not work for their Asian patients."

Language is the key reason preventing Chinese people from accessing the services. The majority of health providers in the mainstream services are English speakers, and therefore, Chinese people might not be able to follow their directions and it might be a major concern when they are using the services.

For Chinese people living alone in New Zealand, they tend to be isolated and lack support from their family members or friends during their treatment. As Helen said, "For Chinese people it probably does not work. Because their family is not here, their best friend is not here, they are quite isolated. There is nobody who can help them."



The existing model among health providers might not fit the Chinese people's situation. For example, western patients being treated for eating disorders might resist drinking milk because of their illness, however, Chinese people might resist milk because of lactose intolerance. Therefore, it was perceived that the current mainstream mental health services would find it hard to meet people's cultural needs.

### **Lack of cultural awareness by health providers**

Cultural difference was perceived to be another vital barrier to offering appropriate mental health services to Chinese people, as reported by most of the respondents. Particularly as mental health is culture bound, people from different ethnicities tend to have different views about mental health. For example, Chris commented:

I have been trained and worked in the Euro-centric, western model, but I recognize that people from different cultures, such as Chinese, always do potentially have different cultural needs, and different health needs when I see a number of people. So I have to bear that in mind, and their presentation may well have a cultural link.

Some participants reported that compared with western people in New Zealand, Chinese people have very different backgrounds, and beliefs. Many cultural differences exist between New Zealand and Chinese culture. For instance, Chinese people are not good at talking about themselves, or explaining their problems, and they are less likely to talk directly about their mental health problems compared with western clients. For example, Helen said that "For Chinese or Asian people they usually do not say I am depressed directly. They probably say 'I do not know why, but I do not feel happy.'" Frank also said:

In many Asian cultures, you do not ask direct questions of people. Eg. 'Do you smoke?' This normally will get a 'no' answer, because we are a no smoking society. So to admit to smoking, is a loss of face. But if doctors ask 'Are you concerned about smoking?' The patients are more likely to give the right answer, 'Yes, I am', because it is not admitting they smoke. But they have implied they do. So it is a way to ask indirect questions.

Cultural understanding might also have an impact on the reliability of assessment and the efficiency of treatment. For example, understanding 'yes' and 'no' might directly affect the accuracy of mental health assessment, and it is also very important for health providers offering their services. As Frank commented:

The other thing is when New Zealanders say yes, they mean yes. But there are many cultures out there where 'yes' means 'no', and 'no' means 'yes'. If you do not understand that, you will suffer all sorts of problems. In New Zealand, we would say something, like 'you are not going to do that again, are you?' and we will say no. But

many Asians will say yes. And you will think: hang on in a minute, why would you go and do it again? But they actually mean ‘yes, I agree with you’. Yes means no in that case.

One Chinese participant reported that in his practice, many Chinese clients come to him to complain that they have been misunderstood by western doctors, and about their frustration over the misunderstanding.

Moreover, both Chinese and western medicine providers all expressed the view that explaining to a client from a different ethnicity could be very hard, and their clients might not understand a certain treatment and therefore, refuse to access the services. For example, Chris and Ian stated:

Explaining the reasons why we are introducing certain treatments, psychological, medication is a little hard to someone who does not come from the Western medical model. For example, I recently had a Chinese patient who was unwell, and need some medications. The patient was depressed, and actually, she has some psychotic thoughts. So I prescribed the medication I thought it might be useful and explained the reasons why, but she did not want to take it. (Chris)

Acupuncture and Chinese medicine all have very good effects. It is very hard to translate exactly the meaning, not only the words, but also the insights of the words which are from thousands of years’ infiltration. If you talk to a Chinese, it will be easy for him to understand, if you talk to a westerner, he will feel confused. (Ian)

A number of respondents also indicated that different cultures need to be differently handled. Moreover, mental health is quite individual, so health providers need to be careful in making judgements about their Chinese clients, because it is possible that although they are all Chinese people, they still have very different cultural backgrounds. For example, they could be from China, Malaysia, or Taiwan. Even China is very broad, and each place has its own culture. Chinese people might also have been resident in New Zealand for lengths of time, they might be a newcomer, or they could have been here for a long time, or some of them might even be born in New Zealand. As Betty noted, “But because of different languages and respect in the culture, they are still not the same. Even China is very broad, and each place has its own culture.” Chris also said:

Just because somebody is from one culture does not mean specific cultural things apply. Particularly, in New Zealand, I meet people who have come across from China, twenty years ago or last year. Somebody, who is Chinese growing up in New Zealand, is very different in culture from somebody perhaps growing up in China and just coming very recently to New Zealand. I think you have to be very careful, not just draw the conclusion based on the fact that somebody is Chinese.

Therefore, without a good understanding of Chinese people and culture, their mental health problems are possibly misunderstood or overlooked by western health providers, and they might not be appropriately treated.

### **Lack of resources for Chinese people**

The majority of the respondents perceived that currently, lack of culturally and linguistically appropriate mental health services for Chinese people in Christchurch is the vital reason that their mental health needs cannot be met. Both western health providers and Chinese providers noted that the lack of sufficient resources for people from different ethnicities makes it very hard to support their clients. For example, Andrew and Chris stated:

At the moment, there is no specific service for mental health for Chinese or Asians, especially for mental health problems. Actually, I have nowhere to send them because of language barriers. There are services, but not specifically for Asians. (Andrew)

From my point of view, there seems to be a gap in the service, although we do not see a huge amount of Chinese people coming through the services, we do see there are difficulties associated with communication, and also trying to identify their needs, their cultural needs, and trying to address those. I work in a western health system, so if there are particular cultural needs, it is quite hard to meet them. (Chris)

### ***Lack of information in Chinese***

Lack of mental health information in Chinese was considered to be one of the important barriers for Chinese people understanding mental health and accessing its services. Although some health-related information has been translated into Chinese, information on mental health is far from adequate. Therefore, many recent Chinese migrants, especially people who came here under the family category, and without good English skills, might not get enough information about how/where to seek mental health support. For example, Chinese elders were identified as one of the high risk groups (described in Section 4.3.1). They are less likely to have good English skills to understand the services set out in the English language. During the interviews, the question, ‘Do you know of any mental health information in the Chinese languages in Christchurch?’ was asked of the participants. Almost all respondents were not aware of any reading mental health information in Chinese in Christchurch. For example, Chris said that “I do not see any information around about medication.” Helen said that “I do not think there is much information about mental health in the Chinese languages. If I know of any, I will put it on our shelf and then patients can take it.” Gay added that “The Community Health Information Centre is part of CDHB services

under the Community and Public Health. They have all the health related resources there, but not many Chinese resources at all.”

### ***Lack of Chinese health providers***

The problem of a shortage of Chinese health providers was identified through the study, particularly Chinese providers working in mental health settings in Christchurch (see Section 4.4.1). Chinese respondents particularly reported that for mental health issues, health professionals from their own ethnicity are needed, because without language and cultural understanding, deeper communication cannot be made, and the treatment might not be effective. At present, even when there are Chinese doctors available, they may not read or speak the most useful language. Although some Chinese nursing students are in training, most of them are interested in people’s physical health, and cultural barriers were considered the most difficult obstacle for Chinese students to study. Therefore, Chinese health professionals are much under-represented compared with the population, and the current resources are hardly able to meet Chinese people’s demands for their services. As Andrew said:

I am the only person [who can serve people in Chinese languages], but so many people out there need help, and I just cannot. But as I said before there is no other place they could go, and in here, they have a person who can speak their language, so they will come with whatever problem they have.

Moreover, the small numbers of Chinese health providers are likely to work in individual organisations, and are not well co-ordinated. For example, Chris said that “But he [a Chinese provider] does not work specifically with Chinese clients. He sees patients as I do for people who need psychiatric input.” Helen expressed the difficulties when she tried to find a service to support their Chinese clients with mental health problems. She said, “We have problems in finding a Chinese counselor. I ring here and then they ask me to ring there, and it is probably just come back to the beginning. The network is not much.” Therefore, currently, a lack of specific connections among Chinese providers in mainstream mental health services is a vital problem in health providers supporting Chinese people to get culturally appropriate mental health care.

### ***Lack of specific Chinese Community based mental health services***

From the literature review, it was found that in the mental health services, around 90 per cent of service users only access community services. In Auckland, the Chinese

community has been successfully supporting Chinese people to overcome cultural barriers, and get quality mental health care by introducing mental illness knowledge, offering information about mental health services, and helping them access the mainstream services. This has been confirmed as an efficient way to help Chinese people and their families in getting appropriate mental health care, and filling the gap between the Chinese culture and their mental health needs. To assess the availability of community-based health care for people with mental health issues, during the interviews, the question, ‘Do you know any Chinese community-based mental health services?’ was asked of each participant. However, none was able to identify any particular community-based mental health services for Chinese people in Christchurch, and reported that the shortage of resources made it hard for them to offer support to Chinese people. As Chris said, “The biggest barrier is lack of any services, specifically for Chinese people, or people of any ethnic group in Christchurch. It is quite dire, particular for Chinese in Christchurch.” Helen also commented:

Sometimes I take a half day to ring and try to find an appropriate service for them but it is just impossible. I think network is really important. There should be somebody who can speak their language to help them, and then they will think they are not isolated in this new country.

### **Understanding Traditional Chinese Medicine**

A few health providers reported that traditional Chinese medicine might be an alternative resource to support Chinese people’s mental health needs in New Zealand. Although Chinese medicine has a different view of assessing and treating disease, it has successfully supported many clients with mental health problems including both western and Chinese clients. The respondents indicated that Chinese people come to TCM commonly for three reasons. Firstly, the providers can speak Chinese; therefore, there are fewer communication barriers. Then, because of cultural familiarity, the Chinese clients are likely to trust them more than the western doctors. Also, they understand how to meet Chinese people’s cultural needs. Lastly, some Chinese clients prefer Chinese medicine for their medical treatment, and they might resist western medicine. Because a few Chinese people might not believe in western medicine, or they think Chinese medicine approaches people’s health from a holistic view, and Chinese medicine is made from natural products, then they think it is more effective and with fewer side-effects than the synthetic chemicals of western medication. For example, Chris and Gay stated:

Chinese Medicine is very good at functional disorders, but Western Medicine is not. For example, stomach-ache, headache, insomnia. Western Medicine does not have

many treatments, just give you a tablet of panadol, when you feel unwell and take one, but it does not solve the real problem. (Chris)

Because doctors here normally like 头痛医头, 脚痛医脚 (Stop-gap measures), and do not normally see people as holistic, we normally say holistic approach which means TCM looks at the patients as a whole person. (Gay)

However, in the current health system, there are many difficulties for Chinese people accessing TCM. First of all, traditional Chinese medicine is practiced as a CAM in New Zealand; it does not have equal status with western medicine. It does not belong to mainstream health care, and especially, it is not part of organised primary health care. Therefore, as an alternative medicine, it tends to be the last choice for people's health problems. Chris, who is a TCM practitioner, said:

When the patients come to see me, they always feel hopeless about the western doctors, and usually the situation is like this: One has no effect at all, nothing happens to the patient. Another one is the effect is not good enough; it does not meet the patients' expectations. Myself, I am for the patients the last choice. Lots of patients live in the hospital for weeks, but there is not much effect, and then they come to see me.

Secondly, professional isolation is another concern in the service. In the mainstream health care system, TCM practitioners tend to be very isolated because they do not have many connections with mainstream health providers. For example, in the current system, although they receive referrals from mainstream providers, they are less likely to refer their patients to any mainstream mental health services. Chris commented on that:

I work for myself. I have some connections with GPs, and some other Acupuncturists or Chinese Medicine practitioners, but not much. Some GPs know me, but I do not know how they know me. Some GPs know me when they need me, they will refer patients to me, but I do not know how they know me, maybe they have a list of Acupuncturists.

Thirdly, high cost in the service is another barrier for people accessing it. Compared to the mainstream services, TCM is less likely to get support from the New Zealand health system. For instance, except for ACC budgeted acupuncture, the health system does not give any support to Chinese medicine. Moreover, most Chinese medicine is imported from overseas, so the cost is relatively high. If many people did not use it, the cost could be even higher. Therefore, as one of the lower income ethnic groups, Chinese people might not be able to access it.

Fourthly, limited support from western practitioners, especially GPs, was seen as

another barrier for people accessing Chinese medicine. At the moment, acupuncture is commonly accepted by western providers. For example, western doctors might refer some clients to TCM service for acupuncture, or invite Chinese medicine providers to do acupuncture in a hospital, but as for Chinese herbs, usually providers will not suggest them to their clients. As Ian said:

Overall, they know Chinese Medicine works, but it is still not very acceptable for them. I have met many cases, I know clearly I can treat their disease very well, but when I ask them, they will say they are going to ask their GPs first. Unfortunately, many GPs do not agree with the Chinese medicine.

Some western providers doubt whether Chinese Medicine is effective, because TCM is experience-based medicine, and is so different from scientific based western medicine, and therefore western providers might not suggest their clients use it. As Gay reported: “It is kind of experience based medicine, and it is very different to my western medical training, in terms of many randomised control trials to show whether it is effective or not effective.” In this study, all Chinese providers and most western providers believed that TCM works for people’s health. One western provider believes that Chinese medicine has a place in medicine, but does not think Chinese medicine could treat most of problems faced by western medicine. However, the Chinese medicine provider argued that although Chinese medicine is different from evidence-based medicine, it was formed from thousands of years’ experience in a country with a large population. It contains very rich knowledge, and it can treat nearly every medical problem. The Chinese providers also pointed out that although the acceptance of TCM has a long way to go, it is good to have an alternative choice for people’s health.

Fifthly, a few health providers indicated that another concern with TCM is the side-effects. As Gay indicated, “For TCM my caution will be the toxic side effects. When you use it, so many things are put together. I really think you need to know it really well to be able to use it.” Some providers and also patients might think Chinese medicine will interact with western medicine, and the western providers are not likely to know how to handle that. Chris’s report reflected that for western doctors, lack of knowledge of Chinese medicine is a big barrier for them in directing and supporting their patients to use it:

If somebody sees it in a culturally different way or has a different point of view on what we call alternative medications, but traditional Chinese medications and where to go for these, I cannot provide any information on that, because I just do not know. So my knowledge is solidly based on western treatment, which means that if somebody has depression for example, and they want to have depression treated in the traditional Chinese medicine way, which is probably just as effective, or more

effective than the way I can treat it, I cannot do that here, because there are no resources there, there is nobody to ask, there is nobody to point Asians towards.

Owing to their training background, Chinese medicine providers are likely to understand both Chinese medicine and western medicine, and know how to use both to achieve a better outcome for their patients.

Sixthly, two Chinese providers reported their concerns about the quality of TCM services in New Zealand. Although TCM providers might register with some particular organizations, currently a lack of national standards to secure quality is a concern. For example, Gay and Ian stated:

If in China, if I really need TCM, I will go to the hospital. But here, in the TCM centre, I am not quite sure what kind of standards they need to meet, or whether they have registration, probably not. I think they just run their businesses. Whether their knowledge or skills meet the standards in China, I am not quite sure. In China, we have big hospitals, and the monitors in place can ensure it is safe. (Gay)

Currently, there are no standards in New Zealand, Australia has them, and we have already talked about this issue for many years, and hope we can have our national standards in New Zealand, but we still do not. (Ian)

#### 4.6. Coping and help-seeking

Theme	Sub-themes
Coping and help-seeking	Not seeking help Self-treating, or informal support Delay in seeking help Going back to China to be treated

This study identified a very passive help-seeking model among Chinese people, and a number of different responses from Chinese patients were reported. Moreover, the health providers indicated that word of mouth and self-referrals are the common ways for Chinese people to access health services. For example, Ella said that “That is why I think once we help one person it just flows on, they find out about our services, what to do.”

Firstly, due to cultural barriers, and personal bias (eg. lack of mental health knowledge, or lack of information of available health services), Chinese people tend not to seek mental health support in the mainstream health services; therefore, they might continue to suffer their mental health problems. As Ian said, “Normally Chinese people rarely actively seek help; they just suffer on their own.” Frank also said, “Because in many Asian countries “face” is involved, people will not seek help. Even if they might know the health service exists; face is lost by accessing it.”



Secondly, Chinese people might self-medicate and self-treat, or seek informal support from their close friends and family members. However, in this situation, they might not get adequate support for their mental health problems. This is mainly reported by Chinese respondents. As Betty said:

From my friend's experience, because of 'face' problems, they would rather treat themselves. Probably they would seek help from their close friends and close family, such as talking to them, and it is like a kind of informal counselling.

Thirdly, Chinese people tend to delay seeking help. However, when their situation becomes desperate, they do come out and seek help, therefore, they are likely to turn up in an emergency situation. For example, Andrew said that "For mental health problems, usually family members call in an emergency situation." Ella also reported that "They can come at any time. Sometimes it is an emergency situation. Sometimes they just become unwell. Sometimes they just waited, waited and waited, and finally they found they had to come."

Fourthly, Chinese clients and their families might decide to go back to China to be treated. For example, one of Chris's recent patients had gone back to China to be treated, to be close to her extended family and be in a familiar cultural environment. Frank also commented:

I do not need to see a doctor, or I am going back to China in 6 months' time and I will see a doctor there. That happens a lot. I just wait, after going back; I will see my doctor. They are not good at looking after their health.

In more serious situations, some people might go back to their home countries to commit suicide. Therefore, the passive help-seeking behaviours might reveal one of the reasons Chinese clients with mental health issues are not often seen in mental health services (stated in the introduction to this chapter).

## 4.7. Possible solutions

Theme	Sub-themes
Possible solutions	Use of an interpreter Building up of specific mental health resources Approaching Chinese people in an appropriate way Education

During the interviews, the respondents reported a few things that might be useful in changing the current situation and meeting Chinese people's mental health needs, including using an interpreter, building up specific mental health resources for Chinese people,

approaching Chinese people in an appropriate way, and offering education to both Chinese people and health providers.

#### **4.7.1. Use of interpreters**

During the interviews, a few health providers pointed out that accessing interpreter services might help Chinese people communicate in the health services. The health providers perceived that communication is very important, especially in mental health care settings, and without efficient English skills, Chinese people's mental health problems (stated in Section 4.5.1) could be very hard to understand. Under these circumstances, using an interpreter might possibly overcome language barriers. During the interviews, most health providers were aware of the interpreter service in Christchurch – 'language line' in the primary health services. All medical practices can use 'language line', and it is free of charge for consumers, paid for by the CDHB. However, a phone line-based interpreting service was considered as only good for a simple conversation 10 to 15 minutes in length. Mental health issues are likely to be complex and might take longer, and phone interpretation may not be effective in supporting people's needs. Fortunately, a face-to-face service is reported as likely to be available in primary health care in 2011 in Christchurch. From then on, people will be able to access an interpreting service in general practice. Moreover, this service will be advertised in the local Chinese media to make sure Chinese people are aware of the service and access it.

Two participants reported that in some hospitals face-to-face interpreting is available. However, although using an interpreter is an important solution to help Chinese clients communicate with health providers, several concerns were highlighted by the health professionals. Firstly, the interpreters are not particularly trained in mental health. One western respondent in particular, indicated that it is very important that the interpreters do not add their own opinions or judgments during the translation. Then, the availability of the service is a concern, because it might take time to find an appropriate interpreter and get access to the service. Finally, communication might not be efficient enough to understand Chinese people's mental health problems, especially as the emotional expression might be lost during the translation. As Betty commented:

So even though a Chinese patient has a translator, if the doctor or nurse does not understand our culture, they will not be able to diagnosis accurately. If your [patient's] English is not good, you will need a translator. Sometimes, it is free, but it takes time. When the psychiatrist talk to them, it is not possible to find a translator immediately, so they will use limited English to communicate. So whether the treatment or communication is effective enough, who knows?

#### **4.7.2. Building up specific mental health resources for Chinese people in Christchurch**

Most respondents emphasised the importance of establishing specific mental health resources for Chinese people, and indicated that it is the fundamental way to support Chinese people with mental health needs. As Auckland has many good resources and experience (stated in Section 4.4.2) in serving Chinese people, learning from Auckland and working closely with their health professionals might be helpful in establishing resources in Christchurch. Although it might take a long time to build up the resources, and also at the beginning not many people will have access, as long as Chinese people know the services are there, they are ready to meet Chinese people's mental health needs. For example, Ella stated:

At least in this way [set up the service and reinforce the messages], they know what to do, where to go when they are ready, and there is somewhere to go, rather than there is nobody that could help. They know there is somebody who is interested in helping them. It is really about meeting them half way.

At present, some resources are building up. For example, Partnership Health Canterbury is creating a website under the refugee and migrant heading. After it finished, it is expected to benefit both health providers and Chinese people. Doctors will be able to download information and give it to patients, and therefore it could give more confidence to doctors. Also, Chinese people would be able to see information in Chinese, especially, if doctors give the information to them, Chinese people would feel more supported and comfortable in the mainstream services.

#### **4.7.3. Approaching Chinese people in an appropriate way**

Three participants addressed the importance of approaching Chinese people in an appropriate way. As Frank said, "There is more likelihood they will actually access the services, if it is promoted to them appropriately." Moreover, a number of suggestions which were perceived that might be useful to approach Chinese people were reported by respondents. Health providers could go outside their offices, and into Chinese communities to reach people who have mental health needs, for example, going to Chinese churches, and language schools run by Chinese people. Developing questionnaires and asking a series of questions about the stress and their feelings in their lives might be useful to discover the underlying mental health problems for their clients. In this way, their clients' mental health problems could be identified and the clients could be supported to get out of difficult situations. Moreover, educational mental health advertisements on TV in Chinese are

expected to be very efficient in improving poor service access. Past experience shows that more Chinese people attend educational seminars in summer, and giving translated information to Chinese people might benefit other members of the family.

#### **4.7.4. Education**

The importance of education was addressed by most respondents. Although it might not show effectiveness in the short term and is hard to measure, it does help improve Chinese people's understanding of mental health and how to access mental health services, and it does help health providers to be aware of the cultural impact of Chinese people's mental health issues, and therefore appropriately treat Chinese clients. For example, Frank said that "Education is the key. Everything we try and do is all down to education. The education is culturally and linguistically appropriate."

##### **Education for Chinese people**

Section 4.5.1 described many barriers for Chinese people, therefore, helping them overcome these barriers might improve poor access to the mental health services. For example, Betty said that "It is better to provide some free lectures in the Chinese community, and pamphlets in the Chinese languages, and involve more Chinese health providers, such as Chinese counseling, community services."

##### ***Attitude shift***

The active and positive attitude shift was encouraged by the health providers. The Chinese providers indicated that not only for themselves, but also for other Chinese migrants, there is a big need for an attitude shift. Especially during the adaptation process, Chinese people need to adjust themselves to fit into the new culture, and take responsibility for looking after their own health. As Ian stated:

I think the personal change in their life is also essential. For example, if you cannot find a job, will you stay in the situation, change to another place, or adjust yourself? Whatever they earn or how high their positions were in the past, they come here and if for any reason they cannot do it in New Zealand, they can go for education again and change to another area.

Actively joining social groups and attending education seminars for new migrants might help Chinese people build up social connections and understand the social system, thereby, having fewer barriers and getting extra support during their resettlement. Gay

commented:

For Chinese people, if they could go to a group, I think their mental health status would be much much better. For example, if they go to the cooking class, they can make some new friends, and they can learn some new cooking styles. It is actually very rewarding and very interesting. They think ‘oh it is very interesting, I try this and I will cook this for my children or for my grandchildren.’ By this means they are more interrelated into New Zealand culture or into the new country: they feel good about these new things, and they feel better about themselves. (Gay)

One respondent reported that after his parents migrated to New Zealand, his father got his driver’s licence when he was 68. Doing this benefits two generations; his parents can live more independently, and he can concentrate better on his work. All these examples and statements reflected that having an appropriate understanding of the social status change and taking a positive action might help Chinese people better adapt into the new cultural environment.

### ***Understand and be aware of mental health problems and seek help***

Several respondents indicated that it is important to educate Chinese people to understand mental health, and to be aware of their mental health problems, and know how to seek support from the services. As many negative cultural attitudes exist among Chinese people, it is necessary to support them overcome stigma, shame and other cultural barriers, and help them access mental health services. It is important for Chinese people to understand that many mental illnesses are treatable, and understand they can get help if they seek it. For example, Frank stated:

If you have a mental health issue, it is an illness, and it is not something you should be embarrassed about. There is help out there. So this is the education we need to start - educating people to seek help. In other words, it is educating people in understanding the differences and making sure they are actually accessing primary health care. So we have to teach people, you do not lose face by seeking help, this is an illness you should not be losing face over. It is a huge culture change here.

One respondent reported that it was only many years later, after she became a health professional and had some education in mental health, that she realised her itchy skin had been due to stress. This example illustrated the importance and effectiveness of long-term education for Chinese people.

### **Education for policy makers and health providers**

Four respondents indicated that attention from policy makers and health professionals

is vital for Chinese people's mental health. For example, Gay said:

One thing is how to let people who make the decisions or who have leadership, understand or educate them about the existing Chinese people and their health issues. Another thing is how to get funding for this is very challenge. Those two things I feel are very important.

Although health providers identified some barriers in the services and know how to improve matters, without supportive policy direction and available funding, the changes in the services might not be able to be made, the education seminars could not be run, and specific mental health services might not be able to be established to meet Chinese people's needs. As Ian stated:

What I am saying are the needs, a phenomena in the society, I do not have the ability to solve these problems. For example, the government invested much money in education, the new migrants can go to free education, or be supported to develop their interests. Compared with local people, the migrants are the vulnerable groups. (Ian)

In any event, helping migrants develop in New Zealand is a very important issue for the resettlement process. Moreover, the respondents reported that in the current mainstream mental health services, educating health providers to understand Chinese culture is essential for them to offer appropriate treatment to their Chinese clients. Especially, health providers need to understand the cultural differences in mental health. For example, Chinese people might present differently with mental health problems. They are likely to complain of their physical health instead of their mental health. Understanding the high rates of lactose intolerance among Asian people might help health providers treat Chinese people's eating disorders. In addition, education could give direction to the health providers about how to treat people from different ethnicities. For example, it is important to give important information to Chinese people with two hands. As Frank reported:

More cultural education is very important. Culture education allows people to understand how to communicate with people. If I give something to somebody, if it is an important piece of paper, I will give to them with two hands because the person will think it is important, I had better keep it. These sorts of things we talk to general practice staff about. If you have a prescription, you actually want somebody to take, give it with two hands. The patients will think oh, this is important; I better go and do it.

#### **4.8. Conclusion**

This chapter has presented the findings from the analysis and has also provided some quotes so that the voices of the participants can be directly heard. The next chapter will

discuss the seven main themes and related sub-themes, and indicate how these findings are consistent with or differ from previous studies, and the new insights gained from this research.

## **Chapter 5: Discussion**

This chapter summaries the past studies, and seven key findings (themes and sub themes) from this descriptive qualitative study, discusses these key findings, and indicates the strengths and limitations of this study.

### **5.1. Overview of the research**

The literature review of Chinese people's mental health and service use issues demonstrated that migration and adaptation associated stresses are the most significant factors impacting on Chinese people's mental health, especially because of language barriers, social isolation, cultural obstacles, and difficulties in employment. In the different cultural environment, Chinese people are likely to be vulnerable, and at a high risk of mental illness in New Zealand. Even though the stocktake of mental health services illustrates that a wide range of mental health services have been established to support people with mental health needs, evidence shows that Chinese people are under-users of mental health services, and language problems, cultural obstacles and stigma were identified as the common barriers for them to seek mental health support and get appropriate care. Previously, a few studies examined Chinese people's mental health issues, however, only little information was found about health providers' perspectives in New Zealand. Therefore, a descriptive qualitative study was chosen via semi-structured face-to-face interviews to describe how health providers perceive and support mental health needs of Chinese patients in Christchurch. The researcher invited a range of providers who engage in the health services and have experience with Chinese people's mental health and service use issues. The idea of the study was to contribute insight and understanding to the issues. By doing this, Chinese people's mental health issues could be understand from a different angle, and further recommendations of how to improve the current situation could be made.

### **5.2. Discussion of themes**

#### **Mental health problems**

The literature review demonstrated that at present, lack of population-based prevalence studies in Chinese is a major obstacle in identifying their mental health issues



(chapter 2.3.3). During the interviews, a number of mental health problems were reported by the participants, including, stress, relationship problems, addiction problems (smoking and gambling), anxiety, eating disorder, depression, suicide and psychosis. Among these, stress, gambling, and depression were the most commonly reported mental health risks among Chinese people. Therefore, further studies are needed to understand these particular issues.

### **Stressors**

Previous studies (Henderson, et al., 2009; Ho, et al., 2003; Kudos Organisational Dynamics Ltd, 2000; Manuel & Mourtala, 2005) demonstrated that migration related stresses impact on people's mental health. For Chinese people, during the process of resettlement, the sources of stress are often reported as language barriers (J. Ng, 2003; Ngai, et al., 2001; Nicola North, et al., 2006), different social environment (Abbott, et al., 2000; DeSouza & Garrett, 2005; Wang, 2000), and unemployment/under-employment (Bartley, 1994; Chiu & Lacey, 2004; N North, et al., 2004; Rose, et al., 1999; Shortt, 1996). During the interviews, these sources of stress were reported by most respondents. Moreover, in the literature review, cultural differences were examined comparing New Zealand to China, and during the interviews, nearly all the respondents indicated that cultural conflicts are one of the major sources of stress affecting Chinese people's mental health. In addition to that, this research identified the good expectation from migration is a basic pressure on Chinese people's new life. However, because of the significant social status change, and difficulties in employment, if their living status does not meet their expectation, their mental health is likely to be affected. The literature review compared the different health system in New Zealand to China, the reports from respondents confirmed that the unfamiliar health system is likely to be an additional stress to Chinese people when they seek health support. According to WHO's definition of mental health (WHO, 2011b), physical health is an important part of people's mental health. In the interviews, a few respondents indicated that personal health problems (physical illness and mental illness) could impact on people's mental health, and physical health and mental health are likely to be inter-related.

### **High risk groups**

The particular vulnerable group of Chinese elders was examined in the literature review (chapter 2.3.4.3), because the extremely difficulties of communication and transportation issues associated their daily living (Asian Public Health Project Team, 2003; DeSouza & Garrett, 2005; Ho, et al., 2003). G. Cheung's study (2010) demonstrated that Chinese elders are likely to delay seek care in the mental health services. During the

interviews, this group was indicated by most participants. Moreover, other groups at high risk of mental health problems among the Chinese population were identified through the study: Chinese students, ‘people in between’, isolated people, and people who came from China already unwell. Some of them are possibly in a combined situation, and therefore, at a higher risk of mental health problems. These high risk groups were not identified in past studies, maybe because of previous studies were mainly based on the Chinese people’s perspectives.

### **Support factors**

The stocktake of mental health services in Christchurch (chapter 2.4) illustrates that a wide range of mental health services have been established to support people with mental health needs. During the interviews, the participants reported that primary mental health services, specialised psychiatric services, mental health services from non-government organizations all could support people’s mental health needs. Especially, the researcher felt the clients are likely to get strong support from the co-operative working styles in the services, for example, team work in a practice, and referrals to each other.

Besides the services themselves, this research offers more insights about how the Chinese people can be better cared when they access these services. Firstly, more openness among Chinese people could give them confidence when they seeking and getting support. Moreover, the openness and flexibility of services can make Chinese people feel more comfortable and meet their needs in the services. Secondly, the supports within a practice location could reduce communication barriers and therefore, it will be easier for Chinese people to access these services. Thirdly, supports from family members have an important role in helping them access mental health services and live at home. Fourthly, the local churches were identified as another supportive source to help Chinese people access mental health services, and offer support to them. Fifthly, the health providers’ own living and working experience are particularly helpful to them in understanding Chinese people and their mental health issues and, therefore, offer efficient support and meet Chinese people’s cultural needs. Sixthly, as one of the lowest income ethnic groups, financial factors could make a big difference to Chinese people’s access problems. Seventhly, supportive resources from Auckland were considered to be a good way to help Christchurch build up its own resources and work for Chinese people’s mental health.

### **Barriers**

Previous studies found that language barriers, face and shame issues, lack of knowledge and awareness of mental health and services (Asian Public Health Project Team,

2003; E. Ng, 2009; R. Ng, et al., 2008; Ngai, et al., 2001; Parackal, et al., 2007; Peterson, et al., 2008; Ran, et al., 2003) are all the common barriers when Chinese people seek and access mental health services. These barriers are all indicated by respondents during the interviews. This research highlighted Ran et al's finding (2003) that when Chinese people need mental health services, some patients would complain to providers about their physical problems. During the interviews, the respondents reported that their Chinese clients commonly present to their services because of their physical health problems, but underlying of that, they discovered their mental health problems.

The respondents also pointed out that the existing care model does not meet Chinese people's mental health needs. Past studies demonstrated that the better policy and funding supports are the key barriers in changing the current situation and establishing cultural and linguistic resources to support Chinese people's health needs (DeSouza & Garrett, 2005; Nicola North, et al., 2006). This research found a same result. Sue's study (1990) indicated that health providers' awareness of the cultural differences is very important in offering quality of care, and most respondents agreed with that. A few studies in New Zealand explored the use of traditional Chinese medicine (Chan, 2004; Nicola North, 2008; Poynton, et al., 2006), and indicated some difficulties when people access it. That research confirmed that lack of acceptance from mainstream providers' supports, high cost in the services, concerns of the quality of safety are all the barriers for Chinese people access it. Moreover, it was indicated that lack of knowledge and resources of TCM are the major barriers in helping western providers supporting their clients in using.

### **Help-seeking model**

Although past studies demonstrated that Chinese people are under-users of mental health services (Asian Public Health Project Team, 2003; Ministry of Health, 2009a, 2010), how they react to their mental health issues and decide to seek help are not clear. This study showed that Chinese people with mental health problems commonly have a passive help-seeking model. They were reported to be reluctant to seek help in the mainstream mental health services, and sometimes choose to go back to China to be treated. Therefore, their decision making process reveals that although many Chinese people need mental health support, they are less likely to access mainstream mental health services in New Zealand.

### **Possible solutions**

During the interviews, the respondents suggested a few ways that might be useful in improving the current health services. Firstly, offering quality face-to-face interpreting

services is one of the possible solutions to reducing communication barriers in the services. It might be helpful to involve more Chinese health providers in the mainstream mental health services, and establish community-based mental health services to bridge the cultural gaps in services to support Chinese people accessing and getting support from mainstream mental health services. Next, it is suggested that approaching Chinese people in an appropriate way might be useful to get a better outcome. Finally, the need to educate Chinese people understand mental health and seeking help is vital in improving the low access issues among Chinese population is noted. Educating health providers and policy makers to understand Chinese people's cultural features and their needs is essential in understanding Chinese people's mental health issues, and therefore provide specific policy and funding support.

### **5.3. Implications of the research**

This paper examined the Chinese people's mental health and service use issues from the health providers' perspectives in Christchurch. Although the literature review has identified some important issues of Chinese people's mental health and service use issues, the descriptive qualitative research provided more insights into these issues. It offers more detailed information about where Chinese people's potential mental health stressors come from, explains why the Chinese clients are not often seen in the clinical settings, illustrates where they go for their mental health care, shows whether they can get enough support for their mental health needs, and raises possible ways of supporting their mental health needs and improving services. Moreover, this study has identified some important mental health problems and some high risk groups among the Chinese population which suggests further studies among these specific populations.

The researcher was impressed by the description of Chinese people's mental health and service use issues as an iceberg. Above sea level, there is little to be seen, and that is the Chinese people with mental health problems presented in clinical settings and in research findings. However, due to the passive help-seeking model of Chinese people, the phenomenon of low utilisation of mental health services might suggest that those who may be in need of mental health care did not seek or access mental health services, therefore, mental health issues are likely to be under-presented among the Chinese population. Moreover, according to the literature review, many important studies did not break the research down into the sub-Asian groups, for example the New Zealand Mental Health Survey (Ministry of Health, 2006c), and therefore, the results might have failed to reveal some important mental

health issues within particular Asian groups. These studies, therefore, might have overlooked Chinese people's mental health issues, and there is a pressing need for further studies to discover the underlying mental health issues among the Chinese population.

The study reveals that 'below sea level', many Chinese people endure hardship and experience mental health problems, especially during the adaptation processes following migration. Therefore, in the new cultural environment, finding ways to assist Chinese people overcoming the challenges of language, culture and employment is vital to help them relieve stress, and prevent the further development of mental health problems during the process of resettlement. Moreover, once Chinese people developed mental health problems, there is a significant need to help them overcome language barriers, cultural barriers and stigma, and come out to seek help. All these issues draw attention to the needs for more accessible and responsive mental health services and education for Chinese people in Christchurch. Especially, there is an expectation that more information in Chinese, and more government supported community initiatives could be available in Christchurch.

Currently, there is a negative cycle in Chinese people's mental health and services use issues: Chinese people do not often use mental health services, so little is known of their issues. Chinese people's mental health and service use issues, therefore, do not get attention from policy makers, and their needs are not considered. Because of this, there is no funding and policy support to improve these situations. Because there is no change in the services, Chinese people do not access services. Therefore, breaking up the negative cycle and establishing a positive cycle is a priority for improving the low access issues among Chinese people.

From the impression of the interviews, Chinese health providers tend to have a better understanding of Chinese culture and the migration background because some of them are not only the health providers but also experienced the process of migration and resettlement themselves. However, the fact that only a few Chinese health providers could be identified who are working in the individual mainstream mental health services in Christchurch is quite a concern in bridging the cultural barriers and meeting Chinese people's mental health needs. The Chinese population is much under-represented in the health professions, and this study demonstrates the need to train and recruit more Chinese mental health providers, and establish specific connections to support Chinese clients in the mainstreamed mental health services.

As part of Chinese culture, traditional Chinese medicine has helped address its people's health problems for thousands of years. However, in the current health system in New Zealand, Chinese people are likely to find this difficult to access. This study revealed the need for national standards to ensure the quality of the service, increasing communication with mainstream medical care, and offering more policy and financial support. By doing this, it might not only meet Chinese people's cultural needs, but also benefit people from other ethnicities.

In summary: This study found that although the Chinese population has increased rapidly in recent ten years in Christchurch, Chinese people's mental health issues have not been given enough attention. Although through migration, many Chinese people are likely to be vulnerable and at high risk of mental health problems, due to the barriers of language, stigma, an unfamiliar health system, poor knowledge and awareness of mental health, few culturally and linguistically supportive mental health resources, the study demonstrated that the current health care system does not meet Chinese people's ongoing mental health needs. Moreover, the low utilisation of mental health services has led to a poor understanding about Chinese people's mental health and service use issues. This study especially indicated that lack of culturally sensitive services is the specific barrier in meeting Chinese people's mental health needs.

Thus, this paper calls for further effort to improve the quality of mental health services for Chinese people. In reaching this aim, Chinese population based studies are the priority in identifying specific mental health needs. It is also calling for a specific mental health policy to supporting Chinese people using the mental health services and encouraging them to take more responsibility for looking after their own mental health. Lack of Chinese community supported services is a major barrier in supporting Chinese people's mental health needs because they could fill the gaps between mental health needs and mental health services. So this paper also calls for establishing Chinese community-based mental health services to support its people in Christchurch. For the mainstream mental health services, they could take more responsibility in offering quality mental health services, treating their patients with cultural respect, and providing a fair opportunity for Chinese people. Therefore, there is a significant need for the quality of mental health care to improve and be more accessible.

#### **5.4. Strengths and limitations:**

The descriptive qualitative research method enables the researcher to describe Chinese people's mental health and service use issues in Christchurch from a health professional perspective. It has identified cultural and other barriers for mental health providers in offering their services for Chinese migrants. Moreover, via the study, recommendations for further research, professional and community education, and mental health services development can be made. Compared with quantitative research, qualitative description is more interpretive, because researchers can use subjective information to describe and summarise Chinese people's mental health and service use issues in detail, so that these issues can be better understood. Moreover, a qualitative study can overcome a quantitative study's limitation regarding the narrative meaning which participants give to the events (Sandelowski, 2000). In this case, the in-depth interviews have helped the researcher to understand how mental health providers perceive and support their Chinese clients and the reasons of their thinking. The qualitative study is also a good way to identify the shortcomings of the current health care system for Chinese people, and explore options for further research (Dew, 2007).

However, a qualitative-based study cannot claim to be representative of all health providers' perceptions, but it can reflect the possible range of perspectives. Furthermore, during the qualitative research, even though the researcher did her best to avoid her personal influence on the study, in reality, the results could be influenced by the researcher's personal biases and idiosyncrasies (Dew, 2007; Starks & Trinidad, 2007). However, during the processes of this research, a number of methods were used to ensure the trustworthiness of the data (detail in chapter 3.2.9). Moreover, the researcher argues that her ten years as a psychiatrist in China could give her a good understanding of the issues in the study. Another concern is that due to the limited time available, the study only could be conducted from one side – the perspectives of mental health providers. It is assumed that there might be a certain gap between health providers' views and Chinese patients' views. Thus, there is a need for further investigation on this issue. However, the fact that the Chinese participants are not only the health providers but also migrants themselves, means that their reflection on their own migration and adaptation experience, might help us to understand other Chinese migrants' difficulties during the resettlement processes.

## **Chapter 6: Conclusion and recommendations**

### **6.1. Conclusion**

A descriptive qualitative study was carried out in Christchurch to explore Chinese people's mental health and service use issues from health providers' perspectives. The overall research question was: How do health providers perceive and support the mental health needs of Chinese patients in Christchurch? During late November 2010 to late January 2011, nine interviewees who have experience with Chinese people's mental health issues were fact-to-face interviewed. During the data collection and analysis, this research followed a systematic process.

The purposes of this research were: to explore health providers' perspectives of key issues affecting the mental health of Chinese patients and their provision of treatment support; to reveal the barriers for health providers in offering mental health services to Chinese patients; to identify what supports providers give to Chinese patients who use their services; to provide recommendations for improvement of services.

According to respondents' reports, during the resettlement and adaptation process, Chinese people are likely to be under stress due to communication problems, being in a different cultural environment, social isolation, and difficulties in finding employment. Moreover, physical illness and mental illness and the unfamiliar health system are the additional stress for their mental health.

From the interviews, two types of barriers were reported, one is from Chinese people themselves (including poor English, stigma and shame issues, poor mental health literacy, and different presentations about their mental health problems), and the other one is from health services (including lack of policy and funding support, lack of cultural awareness by providers, lack of supportive resources in Chinese, and the difficulties when Chinese people access TCM).

A range of mental health services which could support people with their mental health needs were reported by health providers, including primary mental health care with their family doctors, specialised care at mental hospital with a team, and also mental health support from non-government organisation. They are likely to refer a patient to each other and support a client in different situations to suit their needs. Moreover, the respondents reported



some other factors which are also important in supporting Chinese people to get appropriate care, including more openness and flexibility of Chinese people and services, the supports within a practise location, the trustful relationship with providers, support from family and churches, financial factors in the services, providers' past experience, as well as help from Auckland.

In overcoming these barriers, a number of solutions were recommended by the respondents to change the current situation and improve the low access issues for Chinese people. These included offering quality interpreting services, approaching Chinese people in an appropriate way, establishing community-supported mental health services, providing educational seminars to Chinese people and providers.

## **6.2. Recommendations**

Based on the findings from this study, the following recommendations for mental health services development, professional and community education, and further research are made:

### **Mental health service development**

It is recommended that steps be taken:

- To give more policy and financial support to develop more resources in Chinese in Christchurch.
  - Offering more information in Chinese,
  - Recruiting more Chinese professionals to work in mental health services,
  - Establishing a Chinese community-based mental health service,
  - Building up the connections from existing resources in the mainstream mental health services to support each other in meeting Chinese people's different mental health needs.
- To offer more support during Chinese people's resettlement process to relieve their stress and prevent the development of mental health problems.
- For health providers to go into the Chinese community to support people who have mental health needs. For example, based on the current general practice locations, church groups, and other places where there are higher Chinese populations.

### **Professional education**

It is recommended that steps be taken to:

- Educate policy makers to understand Chinese people's mental health and service use issues, so that they can make more responsible policies and provide funding support.
- Educate health providers to understand Chinese people, Chinese culture and the different presentations of mental health problems among the Chinese population in order to improve the quality of the services.
- Encourage more Chinese students to study and work in the mental health field. For example, scholarships could be available for Chinese students who are interested in studying in the mental health area, and they would be able to work for Chinese people in the future.

### **Education of the Chinese community**

It is recommended that steps be taken to:

- Educate Chinese people to understand mental health, the health system, and how to seek help.
- Educate Chinese people to take more responsibility for their own mental health. For example, Chinese people could shift their attitudes, attend social groups and build up the connections with local western and Chinese people, and actively go out and seek help in the new cultural environment.

### **Further research**

It is recommended that steps be taken to:

- Arrange further studies to identify the mental health needs of the Chinese populations, thereby providing evidence-based information for further development of mental health services. Particularly needed are:
  - Population-based studies
  - More detailed research into high risk groups

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## **Appendices**

## Information Sheet

Health Sciences Centre  
Tel: + 64 3 364 2987 ext. 8691, Fax: +64 3 364 3318



### Information

Dear \_\_\_\_\_

You are invited to participate as a subject in the research project: ***Mental health services for Chinese patients in Christchurch.***

The aim of this project is to investigate how health providers perceive and support the mental health needs of Chinese patients in Christchurch.

Your involvement in this project is to take part in a research interview. During the interview, you will be asked questions on your perspectives of your Chinese clients' mental health issues, and the way in which you provide your services. A number of health providers will be identified based on an overview of relevant health services and the personal knowledge of the researcher and her supervisors. We will also be grateful if you can recommend other interviewees who are suitable for this study. It is expected that 10-15 interviews will be undertaken to ensure that adequate data is collected. The interview will be based on a question guide, but you will be encouraged to develop your ideas further. You have the right to decline to answer any specific question without giving any reason. Moreover, no specific information about patients will be sought during interviews. The time and place of interviews will be when/where convenient for you. With your permission, the interview will be taped and then transcribed by the researcher, and there is no third party will have access to the data. If you prefer not to be recorded, notes will be made during the interview. Each interview will be approximately one hour. After the interview, the researcher may wish to ask further questions to clarify your responses either by email or phone.

The research project is being undertaken between March 2010 and April 2011. The interviews will take place from November 2010, and the final report will be completed by April 2011.

Your participation in this study is entirely voluntary. If you do agree to take part in the study, you are free to withdraw from the study at any time, without having to give a reason. You also have the right to withdraw any information provided, and this will not disadvantage you in any way. If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation.

There is no risk to you as a participant, but you will need to set aside time for the interview and, if you consent, maybe answer further questions by email or phone. You may receive a copy of the interview transcript and summary of the completed research, if you wish. When you receive a copy of the transcript, you have the opportunity to correct it and return it to the researcher. From your contribution for this study it will be possible to identify further supportive actions and helpful improvements that would benefit Chinese people with mental health problems.

The project is being carried out as a requirement for masters degree by Qihong (Holly) Zhang under the supervision of Pauline Barnett, who can be contacted at +64 3 364 2987 ext 3692. She will be pleased to discuss any concerns you may have about participation in the project.

A Masters is a public document via the UC Library database, and the results of the project may also be published, but you can be assured of the complete confidentiality of data gathered in this investigation: particular care will be taken to ensure the confidentiality of all data gathered for this study and the anonymity of participants and their institutions in all publications of the findings. Every participant will only be identified with a study number (no name will be used). Moreover, neither you nor your organisation will be identified in the publications. All the information will be kept at the Health Sciences Centre, University of Canterbury. Only the researcher and two supervisors will have access to it.

After you receive this information sheet, you need to consider whether you want to participate in this study. If you agree to do the interview with us, we will be very appreciative of your contribution to this study. If you do not want to participate, there will be no disadvantage for you, and we still thank you for considering our request.

Please feel free to contact the researcher or her supervisor if you have any questions about this study, and I would appreciate it if you could **send me back an email** of your decision to participate by email in one week. If the researcher (Holly) does not receive response from you, she will follow up with another email or phone call to ensure you have received the information sheet.

The consent form will be signed and collected on the day of interview. A copy of the consent form will also be given to you.

The project has been reviewed **and approved** by the University of Canterbury Human Ethics Committee.

Contact details:

Researcher: Dr Qihong (Holly) Zhang

Phone: 0212569293

Email: [qzh37@uclive.ac.nz](mailto:qzh37@uclive.ac.nz)

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Health Sciences Centre

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NEW ZEALAND

Thank you in advance for your contribution.

Yours sincerely

Qihong (Holly) Zhang

## Appendix 2: Interview questions

### Interview questions for:

#### **Research title: Mental health services for Chinese patients in Christchurch**

1. Basic demographic information: Can you give me some background about yourself and your current role?
2. Overall perspective on their Chinese clients: How often do you see a Chinese mental illness patient? In what situation will Chinese patients come to see you? What are the common mental health problems for Chinese mental health patients?
3. Mental health problems of Chinese people: How do you perceive your Chinese mental health patients and their problems?
  - What do you think are the main factors affecting the mental health of Chinese people?
  - Do you notice any difference compared to mental health patients from your own culture? (or compared to patients from other cultures)
4. Treatment supports: What treatment supports can they get from your service? What other supports can you give to your Chinese patients?
5. Barriers to treatment: Can you identify any barrier for you in offering mental health services to your Chinese patients? How do you try to solve these problems?
6. Availability of information in Chinese language: Do you know any mental health information available in the Chinese language? (Chinese mental health providers, community based mental health services) Do you know other health providers who are working in this area that I can interview?
7. Other issues: What else do you think is also important but we have not covered? What are your recommendations for improvement of services?



### Appendix 3: Consent form

Health Sciences Centre

Tel: +64 3 364 2987 ext. 8691, Fax: +64 3 364 3318

Researcher: Dr Qiuhong (Holly) Zhang

Phone: 0212569293

Email: [gzh37@uclive.ac.nz](mailto:gzh37@uclive.ac.nz)

Date \_\_\_\_\_



## CONSENT FORM

### Mental health services for Chinese patients in Christchurch

I have read and understood the description of the above-named project. On this basis I agree to participate as a subject in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved.

I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided.

I note that the project has been reviewed *and approved* by the University of Canterbury Human Ethics Committee.

I consent to my interview being audio taped. Yes ( ) No ( )

I give additional consent for follow up. Yes ( ) No ( )

I wish to receive a copy of the interview transcript. Yes ( ) No ( )

I wish to receive a summary of the final report. Yes ( ) No ( )

NAME (please print): .....

Signature:

Date: